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ABSTRACT

This document presents transcripts and prepared statements of hearings held on November 3-13, 1975 that pertain to national health education and disease prevention, as outlined in House bills H.R. 8278, H.R. 5839, H.R. 7050, H.R. 3205, and H.R. 4444. These bills were written to provide authority for health information, education, and promotion programs, to revise and extend the authority for disease prevention and control programs, and to revise and extend the authority for venereal disease programs. Statements are included from representatives of HEW agencies and life insurance companies, as well as such groups as Consumer Product Safety Commission, American Academy of Pediatrics, Blue Cross, National League of Nursing, Urban Environment Conference, American Public Health Association, National Study for Health Education, Public Citizen's Health Research Group, American Social Health Association, Association of American Physicians and Surgeons, American Public Health Association, and Society for Public Health Education. (LBH)

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NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

U.S. DEPARTMENT OF HEALTH,
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HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

H.R. 8278, H.R. 5839, H.R. 7050, H.R. 3205 and H.R. 4444
(and all similar or identical bills)

BILLS TO PROVIDE AUTHORITY FOR HEALTH INFORMATION, EDUCATION, AND PROMOTION PROGRAMS, TO REVISE AND EXTEND THE AUTHORITY FOR DISEASE PREVENTION AND CONTROL PROGRAMS, AND TO REVISE AND EXTEND THE AUTHORITY FOR VENEREAL DISEASE PROGRAMS

NOVEMBER 3, 4, 10, 11, 12, AND 13, 1975

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American Nurses Association, Constance Holleran, deputy executive director, Government Relations Division.

American Public Health Association:
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- Hopkins, Homer P., Ph. D., member. Executive Board.

American Social Health Association, Samuel R. Knox, director.

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- Kramer, Maurice A., assistant executive director.
- Woolley, Frank K., executive director.

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- Benchoff, Harry E., Supervisory Auditor, Philadelphia Regional Office.
- Farabaugh, Robert V. Assistant Director, Manpower and Welfare Division.
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- Puziss, Milton, M.D., Chief, Bacterial and Mycotic Branch, National Institute of Allergy and Infectious Diseases, National Institutes of Health.
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Interstudy, Paul Elwood, M.D.

National Center for Health Education:
- Carter, Lisle C., Jr., member of the board and executive committee.
- Merwin, Donald J., director, planning and administration.
- Pearson, Clarence, president pro tem.
- National Health Council, Inc., Gerald B. Greenwald, president-elect.

National League of Nursing, Lucie S. Kelly, R.N., Ph. D.

Public Citizen's Health Research Group, Sallie Adams.

Society for Public Health Education, Inc., Beverly G. Ware, D.P.H., president.

Urban Environment Conference, Anita S. Curran, M.D., M.P.H., director, Bureau of Lead Poisoning Control, New York City Department of Health.

NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

MONDAY, NOVEMBER 3, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommitee met, pursuant to notice, at 10 a.m. in room 2123, the Rayburn House Office Building, Paul G. Rogers (chairman) presiding.

Mr. Rogers. The subcommittee will come to order, please.

First of all, may I say we have a delegation from Italy that we are most pleased to have. We welcome you to the hearings.

The Communicable Disease Control Act is not new legislation. During the decade beginning in 1963, the implementation of this act has averted an estimated 24 million cases of measles; prevented an estimated 2,400 deaths; and saved an estimated $1.3 billion.

Conversely, the lack of immunization against rubella has resulted in 30,000 children born with disabilities such as mental retardation and hearing impairments in 1974 alone. The cost of that epidemic is estimated at more than $2 billion and continues to mount as those children grow older.

The fact that more than a third of all children in the 1-to-4 age bracket in this Nation are not protected against polio, measles and rubella, when they could and should be, serves as a grim testament to the indifference of this administration to the health of the children of this Nation.

Science has given us the knowledge to end these diseases but the Department of Health, Education, and Welfare has repeatedly turned its back on the human sufferings inflicted by these diseases under the guise of economy. Yet, the immunization program has proven to be the most effective cost-benefit program we have in health and most probably anywhere in the Government.

It has been estimated that, for an investment of about $15 million, we could eliminate measles in this Nation within 2 or 3 years. I intend to pursue this goal and I think the committee and the Congress will also act start a program to wipe out measles.

I also would hope that the administration today would endorse a National End-Measles Campaign. The insurance carriers of this Nation could also be asked to participate. Currently immunizations are not part of most insurance packages, yet when a youngster is stricken with an immunizable disease, these carriers will pay. We must change this wrong-headed thinking that pays for illness, yet does not have the vision to pay to prevent illness.

These hearings will also consider legislation with respect to lead-based paint poisoning and rodent control. At a later date we intend to hold hearings on title I of this bill which provides for health education.

Mr. Carter. Mr. Chairman, may I make a statement?

Mr. Rogers. Certainly you may.

Mr. Carter I am pleased that the subcommittee is holding hearings on legislative proposals which consider the prevention and control of diseases. I believe that these hearings will help focus our attention on the need to reaffirm the national commitment to the prevention and control of diseases and other conditions which affect our citizens and cause unnecessary human suffering.

The history of communicable disease control contains many advances. Fortunately, we are well beyond the experience of the 19th century when infectious diseases ranked higher on the list of fatal diseases. Now, as the chairman mentioned, measles and rubella are at the lowest point since we began to collect more data.

In 1974, there were only four American families afflicted with polio, while in 1952 there were over 55,000 cases in our country. Also tuberculosis case rates and death rates continued to decline.

Although many dreaded infectious diseases have been virtually eradicated and actually we have not had a case of smallpox to my knowledge in the past 5 or 6 years in this country—this should not be a justification for complacency. In fact, smallpox itself has almost been banished from the Earth. If we read our literature on that, we find that it exists today only in Bangladesh and possibly Eritrea—just in very small numbers. I believe that programs to control and prevent infectious diseases must be continually monitored to assure their continued effectiveness.

I looked forward to hearing from the witnesses about the proposals we have before us as well as any other comments or suggestions that they may have. The fact of the matter is, that as a former health officer many years ago, we used to have very good programs. At that time each school in our country was visited either by a health officer or a nurse, and immunizations were given regularly. Also the health officers in each county provided such immunizations for children as well as child-care clinics. We have drifted away from some of the basic ideas of preventive medicine. I believe we must go back and accent prevention instead of cure and thereby prevent the illnesses which might result.

Thank you, Mr. Chairman.

Mr. Rogers. Thank you, Dr. Carter.

The hearings set for today and tomorrow will deal mainly with title II of H.R. 8278 and all similar or identical bills. Later in the month the subcommittee will continue hearings, on title I of H.R. 8278 and all similar or identical bills. Without objection, the text of those bills and any agency reports that we may have will be placed in the record at this point.

[The text of H.R. 8278, H.R. 8689, H.R. 5839, H.R. 6549, H.R. 8995, H.R. 7050, H.R. 3205, H.R. 5428, H.R. 4444, and H.R. 10515 and agency reports thereon follow:]

[H.R. 8278, introduced by Mr. Rogers (for himself, Mr. Preyer, Mr. Symington, Mr. Scheuer, Mr. Waxman, Mr. Hefner, Mr. Florio, Mr. Carney, Mr. Maguire, Mr. Carter, Mr. Broyhill, Mr. Hastings, and Mr. Heinz) on June 26, 1975; H.R. 8689, introduced by Mr. Patten on July 16, 1975, are identical as follows:]

A BILL

To amend the Public Health Service Act to provide authority for health information, education, and promotion programs, to revise and extend the authority for disease prevention and control programs, and to revise and extend the authority for venereal disease programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "National Health Education and Disease Prevention Act of 1975".

TITLE I—HEALTH INFORMATION, EDUCATION, AND PROMOTION

SHORT TITLE

SEC. 101. This title may be cited as the "National Health Information, Education, and Promotion Act of 1975".

AMENDMENT TO PUBLIC HEALTH SERVICE ACT

SEC. 102. The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE XVII—HEALTH INFORMATION, EDUCATION, AND PROMOTION

"PART A—SECRETARY'S AUTHORITY AND REQUIREMENTS

"GENERAL AUTHORITY

"SEC. 1701. The Secretary, acting through the National Institute for Health Information, Education, and Promotion, shall—

"(1) formulate national goals, and a strategy to achieve such goals, with respect to health information, education, and promotion, preventive health services, and education in the appropriate use of medical care;

"(2) analyze the necessary and available resources for implementing the goals and strategy formulated pursuant to paragraph (1), and recommend appropriate educational and quality assurance policies for the needed manpower resources identified by such analysis;

"(3) undertake and support necessary activities and programs to—

"(A) incorporate appropriate health education components into every facet of our society, especially into all aspects of education and health care,

"(B) increase the application and use of health knowledge, skills, and practices by the general population in its patterns of daily living, and

"(C) establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health education concepts;

"(4) undertake and support research and demonstrations respecting health information, education and promotion, preventive health services, and education in the appropriate use of medical care;

"(5) undertake and support appropriate training in, and for the operation of programs concerned with, health information, education, and promotion, preventive health services, and education in the appropriate use of medical care;

"(6) undertake and support, through improved planning and implementation of tested models and evaluation of results, effective and efficient programs respecting health information, education, and promotion, preventive health services, and education in the appropriate use of medical care;

"(7) foster the exchange of information respecting, and cooperation in the conduct of, research, demonstration, and training programs respecting, and programs in, health information, education, and promotion, preventive health services, and education in the appropriate use of medical care; and

"(8) provide technical assistance in the programs referred to in paragraph (7).

The Secretary shall administer this title in a manner consistent with the national health priorities set forth in section 1502 and with health planning and resource development activities undertaken under titles XV and XVI.

"FEDERAL PROGRAMS

"SEC. 1702. The Secretary shall—

"(1) if he determines that legislation being considered by the Congress should include provisions respecting health information, education or promotion, preventive health services, or education in the appropriate use of medical care, make recommendations to the Congress for the inclusion of such provisions in such legislation;

"(2) identify Federal legislative proposals which are not in the interest of the public health, make recommendations for appropriate changes in such proposals which would, if enacted, make the proposals consistent with the public health, and make public such recommendations;

"(3) identify Federal programs and actions which are not in the interest of the public health, make recommendations to the persons responsible for such programs and actions for appropriate changes in them which would, if implemented, make them consistent with the public health, and make public such recommendations; and

"(4) establish a liaison with other Federal entities engaged in activities relating to health information, education, or promotion, preventive health services, or education in the appropriate use of medical care, including the Consumer Product Safety Commission, the Department of Agriculture, the Environmental Protection Agency, the Federal Trade Commission, the Federal Communications Commission, the Office of Management and Budget, and the Department of Defense, for the purpose of coordinating, assisting, and evaluating such activities.

"REQUIREMENTS APPLICABLE TO PROVIDERS OF INSTITUTIONAL MEDICAL CARE

"SEC. 1703. (a) (1) The Secretary shall not approve an application for a grant or contract under this Act, the Community Mental Health Centers Act, title III of the

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, or title IV of the Drug Abuse Office and Treatment Act of 1972 for a program or project in or through which institutional health services are to be provided unless such application contains assurances satisfactory to the Secretary that the standards (developed under section 1712 (a) (6)) for the health education of patients receiving such institutional health services will be met by the applicant in providing such services with the assistance of funds provided under such grant or contract. As used in this title, the term 'institutional health services' has the same meaning as is given such term by section 1531 (5).

"(2) Paragraph (1) shall apply with respect to applications for grants and contracts to be made from appropriations for fiscal years beginning at least twelve months after the development of standards under section 1712 (a) (6).

"(b) (1) (A) No payment may be made to any State under title XIX of the Social Security Act with respect to charges of providers in such State of institutional health services unless such providers provide to the patients, receiving such services, health education in a form and a manner which meets the standards developed under section 1712 (a) (6). Payments to a State under such title for an institutional health service shall include reimbursement for the provision, in connection with the provision of such service, of health education in a form and manner meeting such standards.

“(B) The Secretary shall provide to such providers and to the States appropriate technical assistance in meeting such standards.

“(2) Paragraph (1) (A) shall apply with respect to payments under title XIX of the Social Security Act for calendar quarters beginning at least twelve months after the development of standards under section 1712 (a) (6).

“(c) (1) (A) The amount of the Federal payment under title XIX of the Social Security Act to any State for any calendar quarter shall be reduced by an amount equal to 2 per centum of the amount that would be paid to such State but for this subparagraph unless the State provides (i) in a form and manner meeting the standards developed under section 1714 (6) to the residents of its State information respecting the costs and quality of medical care provided in the State, and (ii) in a form and manner meeting the standards developed under section 1714 (7) to the residents of its State information respecting health insurance policies offered within the State. A State which provides (in such form and manner) such information to the residents of its State may include in the administrative costs for which it may receive reimbursement under such title the costs of so providing such information.

"(B) The Secretary shall provide to the States such technical assistance as may be necessary for the States to comply with subparagraph (A).

"(2) Paragraph (1) (A) shall apply with respect to payments under title XIX of the Social Security Act for calendar quarters which begin at least twelve months after the development of standards under sections 1714 (6) and (7).

"(d) (1) No payment may be made to any State under title XIX of the Social Security Act with respect to charges or costs of providers in such State for the provision of a preventive health measure or service under any condition of use with respect to which the Secretary determines under section 1712 (a) (7) such measure or service is not cost effective.

"(2) Paragraph (1) shall apply with respect to payments under title XIX of the Social Security Act for calendar quarters beginning at least thirty-six months after the date of the enactment of this title.

"REPORTS

"SEC. 1704. (a) (1) The Secretary, after consultation with the National Council on Health Information, Education, and Promotion, shall submit an annual report to the

Congress on the status of health information, education, and promotion, preventive health services, and education in the appropriate use of medical care. Each such report shall include—

"(A) a statement of the activities carried out under this title during the year for which the report is submitted and the extent to which each such activity achieves the purposes of this title;

"(B) a statement of the activities intended to be carried out during the year following the year for which the report is submitted, including a statement of the purpose of and an estimate of the cost of such activities;

"(C) an assessment of the manpower resources needed to carry out programs relating to health information, education, and promotion, preventive health services, and education in the appropriate use of medical care, and a statement describing the activities carried out under this title designed to prepare teachers and other manpower for such programs; and

"(D) such recommendations as the Secretary considers appropriate for legislation respecting health information, education, and promotion, preventive health services, and education in the appropriate use of medical care.

"(2) The Office of Management and Budget may review the Secretary's report under paragraph (1) before its submission to the Congress, but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report.

"(b) Whenever the National Council on Health Information, Education, and Promotion disagrees with any aspect of any report submitted by the Secretary pursuant to subsection (a) (1) or disagrees with any action taken by the Secretary under this title, it may submit to the Congress and the Secretary such reports as it deems appropriate with respect to such disagreement.

"PART B—NATIONAL INSTITUTE FOR HEALTH INFORMATION, EDUCATION, AND PROMOTION

"ESTABLISHMENT OF CENTER; AUTHORIZATION OF APPROPRIATIONS

"SEC. 1711. (a) There is established in the Department of Health, Education, and Welfare the National Institute for Health Information, Education, and Promotion (hereafter in this title referred to as the 'Institute') which shall be under the direction of a Director who shall be appointed by the Secretary and supervised by the Assistant Secretary for Health (or such other officer of the Department as may be designated by the Secretary as the principal adviser to him for health programs). The Director of the Institute shall be paid at a rate equal to the rate of basic pay in effect for level IV of the Executive Schedule.

"(b) For payments under grants and contracts under this part there are authorized to be appropriated $40,000,000 for fiscal year 1976, $50,000,000 for fiscal year 1977, and $60,000,000 for fiscal year 1978.

"RESEARCH PROGRAMS

"SEC. 1712. (a) The Secretary, acting through the Institute, shall conduct and support by grant or contract (and encourage others to support) research in health information, education, and promotion, preventive health services, and education in the appropriate use of medical care. The Secretary shall also—

"(1) develop a plan for such research and in connection with the development of such plan—

"(A) determine the scope and nature of such research which is currently being conducted,

"(B) determine the scope and nature of such research that could and should be conducted, and

"(C) establish priorities for such research;

"(2) support by grants and contracts research projects to be conducted in accordance with the plan developed under paragraph (1);

"(3) provide consultation and technical assistance to persons who need help in preparing research proposals or in actually conducting research;

"(4) determine the best methods of disseminating information concerning personal health behavior, preventive health services and the use of medical care and of affecting behavior so that such information is applied to maintain and improve health, and prevent disease, reduce its risk, or modify its course or severity;

"(5) determine and study environmental, occupational, social, and behavioral factors which affect and determine health and ascertain those programs and areas for which educational and preventive measures could be implemented to improve health as it is affected by such factors;

"(6) within the two-year period beginning on the date of the enactment of this title, develop models and standards for the education, by providers of institutional health services, of individuals receiving such services respecting the nature of the institutional health services provided the individuals and the symptom, sign, or diagnosis which led to the provision of such services; and

"(7) enumerate and assess specific preventive health measures and services with respect to their cost effectiveness under various conditions of use.

"(b) The Secretary, acting through the National Center for Health Statistics (established under section 306), shall make a continuing survey of the needs, interest, attitudes, knowledge, and behavior of the American public regarding health and medical care. The Secretary shall use the findings of such surveys and the findings of similar surveys conducted by national and community health education organizations, and other organizations and agencies as a basis for formulating policy respecting health information, education, and promotion, preventive medicine, and education in the appropriate use of medical care.

"COMMUNITY PROGRAMS

"SEC. 1713. (a) The Secretary, acting through the Institute, shall conduct and support by grant or contract (and encourage others to support) new and innovative programs in health information, education, and promotion, preventive health services, and education in the appropriate use of medical care, and shall specifically—

"(1) support demonstration and training programs in such matters, which programs (A) shall be in hospitals, ambulatory care settings, schools, day care programs for children, and other appropriate settings representative of broad cross sections of the population, (B) shall focus on objectives that are measurable, and (C) shall emphasize the preventive or moderation of illness or accidents that appear controllable through individual knowledge and behavior;

"(2) provide consultation and technical assistance to organizations that request help in planning, operating, or evaluating programs in such matters;

"(3) develop health information, education, and promotion materials including (A) model curriculums for the training of health professionals by medical, dental, and nursing schools, schools of public health, and other institutions engaged in training health professionals, (B) model curriculums to be used in elementary and secondary schools and institutions of higher learning, (C) materials for public service use by the printed and broadcast media, and (D) materials for providers of health care to use in providing health education to their patients; and

"(4) support the development of toll-free telephone systems which use recorded tapes or other methods to provide the public with health information, information on available health services, crisis information, and directions for obtaining health related publications.

"(b) (1) The Secretary shall, by grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and establishing and operating existing and new health education centers, for multidisciplinary research, evaluations, and demonstrations respecting health information, education, and promotion, preventive health services, and education in the appropriate use of medical care. To the extent practicable, the Secretary shall approve, in accordance with the requirements of this subsection, a number of applications for grants and contracts under this subsection which will result in at least ten of such health education centers being operational in each fiscal year.

"(2) (A) No grant or contract may be made under this subsection for planning and establishing a health education center unless the Secretary determines that when it is operational it will meet the requirements listed in subparagraph (B) and no grant or contract may be made for the operation of such a center unless the center meets such requirements.

"(B) The requirements referred to in subparagraph (A) respecting a health education center are as follows:

"(i) There shall be a full-time director of the center who possesses a demonstrated capacity for sustained productivity and leadership in the field of health information, education, and promotion, preventive health services, and education in the appropriate use of medical care, and there shall be such additional full-time professional staff as may be appropriate.

"(ii) The center shall (I) be located within an established academic or research institution with departments and resources appropriate to the programs of the center, and (II) have working relationships with health service delivery and educational systems where experiments and demonstrations in such matters may be initiated and evaluated.

"(iii) The center shall select problems in health information, education, and promotion, preventive health services, and education in the appropriate use of medical care for research, demonstrations, and evaluations on the basis of (I) their regional or national importance, (II) the unique potential for definitive research on the problem, and (III) opportunities for local application of the research findings.

"(iv) Such additional requirements as the Secretary may by regulation prescribe.

"INFORMATION PROGRAMS

"SEC. 1714. The Secretary, acting through the Institute, shall conduct and support by grant or contract (and encourage others to support) such activities as may be required to make information respecting health information, education, and promotion, preventive health services, and education in the appropriate use of medical care available to the public, consumers of medical care, providers of such care, schools, and others who are or should be informed respecting such matters. Such activities shall include at least the following:

"(1) (A) The publication of a journal for health professionals. The journal shall be published at least quarterly and shall include current information on research and developments in matters relating to health information, education, and promotion, preventive health services, and education in the appropriate use of medical care.

"(B) The publication of a journal for the general public. The journal shall be published at least monthly and shall include, in readily understandable form, current and useful information in the matters described in subparagraph (A).

"(2) A continuing review of health information, education, and promotion in advertising to evaluate its content and impact. If the health information, education, or promotion aspect of any advertising is determined to be false or misleading—

"(A) the Federal Trade Commission shall be notified of the determination,

"(B) the determination shall be made available to the general public, and

"(C) the communications media which presented such advertising shall be given information, for transmittal to the public, served by such media, which is responsive to the false or misleading part of such advertising.

"(3) The publication of information, pamphlets, and other reports which are specially suited to interest and instruct the health consumer, which information, pamphlets, and other reports shall be updated annually; shall pertain to the individual's ability to improve and safeguard his own health; shall include material, accompanied by suitable illustrations, on child care, family life and human development, disease prevention (particularly prevention of pulmonary disease, cardiovascular disease, and cancer), physical fitness, dental health, environmental health, nutrition, safety and accident prevention, drug abuse and alcoholism, mental health, and venereal diseases; and shall be designed to reach populations of different languages and of different social and economic backgrounds.

"(4) The establishment of a national information clearinghouse to facilitate the exchange of information concerning the matters described in paragraph (1) (A), to facilitate access to such information, and to assist in the analysis of issues and problems relating to such matters.

"(5) Securing the cooperation of the communications media, providers of medical care, schools, and others in activities designed to promote and encourage the use of health maintaining information and behavior.

"(6) Within the two-year period beginning on the date of the enactment of this title, the development of models and standards for the publication by States, insurance carriers, and others of information for use by the public respecting the cost and quality of medical care.

"(7) Within the two-year period beginning on the date of the enactment of this title, the development of models and standards for the publication by States of information for use by the public respecting health insurance policies currently being offered, including information on the benefits provided by the various types of such-policies, the premium charges for such policies, exclusions from coverage or eligibility for coverage, and the ratio of the amounts paid as benefits to the amounts received as premiums.

"(8) Assess, with respect to the effectiveness, safety, cost, and required training for and conditions of use, of new aspects of health care, and new activities, programs, and services designed to improve human health (including megavitamin therapy, acupuncture, biofeedback, and structural integration (commonly known as 'Rolfing')) and publish in readily understandable language for public and professional use such assessments and, in the case of controversial aspects of health care, activities, programs, or services, publish differing views or opinions respecting the effectiveness, safety, cost, and required training for and conditions of use, of such aspects of health care, activities, programs, or services.

"NATIONAL COUNCIL ON HEALTH INFORMATION, EDUCATION, AND PROMOTION

"SEC. 1715. (a) (1) There is established the National Council on Health Information, Education, and Promotion (hereafter in this section referred to as the 'Council').

"(2) The Council shall consist of nineteen members appointed by the Secretary. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who have distinguished themselves in the fields of medicine (including preventive medicine), dentistry, health education, epidemiology, the social and behavioral sciences, nutrition, and the provision of health services; persons who are representative of the interests of the general public (including representatives of business, labor, and consumer groups); and persons from government. Each member shall hold office for a term of four years, except that the Secretary may stagger the terms of members first appointed to the Council, and any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms.

"(3) Members (other than members who are officers or employees of the United States) of the council shall be entitled to receive for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the council compensation at rates fixed by the Secretary, but not exceeding the daily equivalent of the basic rate of pay in effect for grade GS-18 of the General Schedule; and while so serving away from their homes or regular places of business each member may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

"(b) (1) The Council shall meet as frequently as the Secretary deems necessary. Upon request of five or more members, it shall be the duty of the Secretary to call a meeting of the Council.

"(2) It shall be the function of the Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to the functions of the Institute. The Council shall make an annual report to the Secretary and to the Congress on the performance of its functions, including any recommendations it may have with respect thereto.

"(c) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical, and other administrative support services and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare, as the Council may require to carry out its functions.".

SEC. 103. (a) Section 502 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amended by inserting after paragraph (p) the following new paragraph:

"(q) In the case of any prescription drug, unless, pursuant to regulations promulgated by the Secretary, the drug bears labeling stating (1) the various names under which the drug is dispensed, and (2) information (in readily understandable language) relating to the purposes for which such drug is used, the proper storage and handling of such drug, and possible adverse effects resulting from the use of such drug. Regulations of the Secretary under this paragraph shall authorize a practitioner, who is licensed by law to prescribe and administer drugs, to order in prescribing a drug for a particular individual that the drug not bear the labeling prescribed by the first sentence of this paragraph.".

(b) The amendment made by subsection (a) shall take effect after two years after the date of the enactment of this Act.

TITLE II—DISEASE PREVENTION AND CONTROL

SHORT TITLE

SEC. 201. This title may be cited as the "Disease Prevention and Control Amendments of 1975".

AMENDMENTS TO SECTIONS 311 AND 317

SEC. 202. (a) Effective with respect to grants under section 317 of the Public Health Service Act made from appropriations under such section for fiscal years beginning after June 30, 1975, section 317 of such Act is amended to read as follows:

"DISEASE PREVENTION AND CONTROL PROGRAMS

"SEC. 317. (a) The Secretary may make grants to States, and in consultation with State health authorities, to public and nonprofit private entities to assist them in meeting the costs of disease prevention and control programs.

"(b) (1) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe and shall meet the requirements of paragraph (2).

"(2) An application for a grant under subsection (a) shall—

"(A) set forth with particularity the objectives (and their priorities, as determined in accordance with such regulations as the Secretary may prescribe) of the applicant for each of the disease prevention and control programs it proposes to conduct with assistance from a grant under subsection (a);

"(B) contain assurances satisfactory to the Secretary that, in the year during which the grant applied for would be available, the applicant will conduct such programs as may be necessary (i) to develop an awareness in those persons in the area served by the applicant who are most susceptible to the diseases referred to in subsection (e) (1) of appropriate preventive behavior and measures (including immunizations) and diagnostic procedures for such diseases, and (ii) to facilitate their access to such measures and procedures; and

"(C) provide for the reporting to the Secretary of such information as he may require concerning (i) the problems, in the area served by the applicant, which relate to any disease referred to in subsection (e) (1), and (ii) the disease prevention and control programs of the applicant for which a grant is applied for.

In considering such an application the Secretary shall take into account the relative extent, in the area served by the applicant, of the problems which relate to one or more of the diseases referred to in subsection (e) (1) and the extent to which the applicant's program is designed to eliminate or reduce such problems. The Secretary shall give special consideration to applications for programs which will increase the immunization rates of any population identified as not having received, or as having failed to secure, the generally recognized disease immunizations. The Secretary shall give priority to applications submitted for disease prevention and control programs for communicable diseases.

"(c) (1) Each grant under subsection (a) shall be made for disease prevention and control program costs in the one-year period beginning on the first day of the first month beginning after the month in which the grant is made.

"(2) Payments under grants under subsection (a) may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of this section.

"(3) The Secretary, at the request of a recipient of a grant under subsection (a), may reduce the amount of such grant by—

"(A) the fair market value of any supplies (including vaccines and other preventive agents) or equipment furnished the grant recipient, and

"(B) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the recipient and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such recipient and for the purpose of carrying out a program with respect to which the grant under subsection (a) is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based.

"(d) (1) The Secretary may conduct, and may make grants to and enter into contracts with public and nonprofit private entities for the conduct of—

"(A) training for the administration and operation of disease prevention and control programs, and

"(B) demonstrations and evaluations of such programs.

"(2) No grant may be made or contract entered into under paragraph (1) unless an application therefor is submitted to and approved by the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(e) The Secretary shall coordinate activities under this section respecting disease prevention and control programs with activities under other sections of this Act respecting such programs.

"(f) For purposes of this section, the term 'disease prevention and control program' means a program which is designed and conducted so as to contribute to national protection against diseases of national significance which are amenable to reduction, including tuberculosis, rubella, measles, poliomyelitis, diphtheria, tetanus, whooping cough, and other communicable diseases (other than venereal diseases), and diabetes, diseases borne by rodents, lead poisoning, hypertension, pulmonary diseases, cardiovascular diseases, and Rh disease. Such term also includes vaccination programs, laboratory services, studies to determine the disease prevention and control needs of the States and the means of best meeting such needs, the provision of information and education services respecting disease prevention and control, and programs to encourage behavior which will prevent disease and the use of preventive measures and diagnostic procedures. Such term also includes any program or project

(1) for rodent control for which a grant was made under section 314 (e) for the fiscal year ending June 30, 1975, and (2) for lead-based paint poisoning control for which a grant was made under title I of the Lead-Based Paint Poisoning Prevention Act for such fiscal year.

"(g) (1) For the purpose of payments pursuant to grants and contracts under subsections (a) and (d) there are authorized to be appropriated $35,000,000 for fiscal year 1976, $40,000,000 for fiscal year 1977, and $45,000,000 for fiscal year 1978.

"(2) Not to exceed 50 per centum of the amount appropriated for any fiscal year under paragraph (1) may be used by the Secretary for grants for such fiscal year under section 318.

"(3) Except as provided in section 318, no funds appropriated under any provision of this Act other than paragraph (1) of this subsection may be used to make grants in any fiscal year for disease prevention and control programs if (A) grants for such programs are authorized by subsection (a), and (B) all the funds authorized to be appropriated under this subsection for that fiscal year have not been appropriated for that fiscal year and obligated in that fiscal year.

"(h) The Secretary shall submit to the President for submission to the Congress on January 1 of each year (1) a report (A) on the effectiveness of all Federal and other public and private activities in preventing and controlling the diseases referred to in subsection (e) (1), (B) on the extent of the problems presented by such diseases, (C) on the effectiveness of the activities, assisted under grants and contracts under this section, in preventing and controlling such diseases, and (D) setting forth a plan for the coming year for the prevention and control of such diseases; and (2) a report (A) on the immune status of the population of the United States, and (B) identifying, by area, population group, and other categories, deficiencies in the immune status of such population.

"(i) (1) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to an agency or a political subdivision of a State under provisions of Federal law (other than this Act) and which are available for the conduct of disease prevention and control programs from being used in connection with programs assisted through grants under subsection (a).

"(2) Nothing in this section shall be construed to require any State or any agency or political subdivision of a State to have a disease prevention and control program which would require any person, who objects to any treatment provided under such a program, to be treated or to have any child or ward treated under such a program.".

(b) Section 311 (c) of the Public Health Service Act is amended to read as follows:

"(c) (1) The Secretary shall develop (and may take such action as may be necessary to implement) a plan under which personnel, equipment, medical supplies, and other resources of the Service and other agencies under the jurisdiction of the Secretary may be effectively used to control epidemics of any disease referred to in section 317 (e) (1) and to meet other health emergencies or problems involving or resulting from disasters or any such disease. The Secretary may enter into agreements providing for the cooperative planning between the Service and public and private community health programs and agencies to cope with health problems (including epidemics and health emergencies) resulting from disasters or any disease referred to in section 317 (e) (1).

"(2) The Secretary may, at the request of the appropriate State or local authority, extend temporary (not in excess of forty-five days) assistance to States or localities in meeting health emergencies of such a nature as to warrant Federal assistance. The Secretary may require such reimbursement of the United States for aid provided under this paragraph as he may determine to be reasonable under the circumstances. Any reimbursement so paid shall be credited to the applicable appropriation for the Service for the year in which such reimbursement is received.".

AMENDMENTS RESPECTING VENEREAL DISEASES

SEC. 202. (a) Subsections (b) (2) and (d) (2) of section 317 of the Public Health Service Act are each amended by striking out "two" and inserting in lieu thereof "five".

(b) Subsection (a) of such section is amended by striking out "public authorities and" and inserting in lieu thereof "public and nonprofit private entities and to".

(c) Subsection (d) (1) (B) of such section is amended by inserting before the semicolon at the end the following: "and routine testing, including laboratory tests and followup systems".

(d) Subsection (d) (1) (E) of such section is amended by striking out "control" and inserting in lieu thereof "prevention and control strategies or activities".

(e) (1) Subsection (c) is repealed.

(2) Subsection (e) (1) of such section is amended by striking out "or (d)" and inserting in lieu thereof "or (c)".

(3) The last sentence of subsection (e) (4) of such section is amended by striking out the semicolon and all that follows through "such recipient".

(4) Subsection (g) of such section is amended by strik-

ing out ", (c), and (d)" and inserting in lieu thereof "and (c)".

(5) Subsections (d), (e), (f), (g), and (h) of such section are redesignated as subsections (c), (d), (e), (f), and (g), respectively.

(f) Subsection (e) of such section (as so redesignated) is amended by striking out "317 (d) (4)" and inserting in lieu thereof "317 (f) (2)".

TITLE III—MISCELLANEOUS AMENDMENT

SEC. 301. (a) Section 2 (f) of the Public Health Service Act is amended to read as follows:

"(f) Except as provided in sections 314 (g) (4) (B), 317 (h) (2), 318 (c) (1), 330 (a) (2), 355 (5), 361 (d), 1002 (c), 1201 (2), 1410 (13), 1531 (1), and 1633 (1), the term 'State' includes, in addition to the several States, only the District of Columbia, Guam, the Commonwealth of Puerto Rico, and the Virgin Islands.".

(b) (1) Section 361 (d) is amended by adding at the end thereof the following: "For purposes of this subsection, the term 'State' includes, in addition to the several States, only the District of Columbia.".

(2) Section 1410 is amended by adding after paragraph (12) the following new paragraph:

"(13) The term 'State' includes, in addition to the several States, only the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.".

[H.R. 5839, introduced by Mr. Carter on April 10, 1975;
H.R. 6549, introduced by Mr. Carter (for himself, Mr. Brown of California, Mr. Conyers, Mr. Downey, Mr. Eilberg, Mr. Koch, Mr. Matsunaga, Mr. Preyer, Mr. Solarz, Mr. Symington, and Mr. Waxman) on April 30, 1975, and
H.R. 8995, introduced by Mr. Carter (for himself, Mr. Brown of California, Mr. Conyers, Mr. Downey of New York, Mr. Eilberg, Mr. Florio, Mr. Koch, Mr. Matsunaga, Mr. Preyer, Mr. Solarz, Mr. Symington, and Mr. Waxman) on July 29, 1975,
are identical as follows:]

A BILL

To provide for the establishment of the National Center for Health Education and Promotion and the Institution for Health Education and Promotion to advance the national health; to reduce preventable illness, disability, and death; to moderate self-imposed risks; to promote progress and scholarship in consumer health education and preventive medicine; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "National Health Education and Promotion Act of 1975".

TITLE I—NATIONAL CENTER FOR HEALTH EDUCATION AND PROMOTION

ESTABLISHMENT OF NATIONAL CENTER FOR HEALTH EDUCATION AND PROMOTION

SEC. 101. (a) There is established in the Department of Health, Education, and Welfare the National Center for Health Education and Promotion (hereafter in this Act referred to as the "Center") which shall be under the direction of a Director who shall be appointed by the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the "Secretary") and supervised by the Assistant Secretary for Health (or such other officer of the Department as may be designated by the Secretary as the principal adviser to him for health programs).

(b) The Center shall consist of not less than the following four divisions: The division for research in health education and preventive medicine; the division for community health education programs; the division for communications in health education; and the division of Federal programs. The head of each division shall be appointed by the Director by and with the advice and consent of the Secretary.

GENERAL AUTHORITY

SEC. 102. The Secretary, acting through the Center, shall—

(1) formulate a national strategy and national goals with respect to health education, health promotion, and preventive medicine;

(2) develop an integrated and comprehensive perspective on national health education, health promotion, and preventive medicine needs and resources, and recommend appropriate educational and certifying policies for health education and preventive medicine manpower;

(3) incorporate appropriate health education components into every facet of our society, especially into all aspects of health care and educational programing;

(4) increase the application of health knowledge, skills, and practices by the general population in their patterns of daily living;

(5) increase the effectiveness and efficiency of health education and preventive medicine programs through improved planning, implementation of tested models, and evaluation of results;

(6) establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health education concepts; and

(7) foster information exchanges and cooperation among health education providers, consumers, and supporters.

The Secretary shall carry out this title in a manner consistent with the national health priorities set forth in section 1502 of the Public Health Services Act and with activities undertaken under title XV of such Act (relating to health planning and development).

SPECIFIC PROGRAMS

SEC. 103. (a) The Secretary, acting through the division for research in health education and preventive medicine, shall conduct and support (and encourage others to support), research in health education, health promotion, and preventive medicine. The Secretary, acting through the division, shall—

(1) determine the scope and nature of health education research currently being done;

(2) determine the scope and nature of health education research that could be done;

(3) rank the needed research projects in order of priority;

(4) initiate or stimulate studies that are not being made and support by grants and contracts projects that are determined to be necessary;

(5) provide consultation to persons who need help in preparing research proposals or in actually conducting research;

(6) determine which are the best methods of dis-

seminating information on the value of preventive measures in health care and of affecting behavior so that knowledge is applied to prevent disease, reduce its risk, or modify its course or severity;

(7) determine factors in social behavior which impact on health and determine the interaction of sociological determinants with the field of health education;

(8) ascertain what changes could be expected in cost and cost-benefit if currently known methods and procedures in preventive medicine were applied to the delivery system; and

(9) review external factors which affect environmental and occupational health; ascertain those programs and areas for which educational and preventive measures could be implemented to improve environmental and occupational health; and engage in research and policy formulation in such areas as accidents, nutrition, dental care, occupational health and safety, and environmental stress.

The Secretary, acting through the National Center for Health Statistics (established under section 306 of the Public Health Service Act), shall make continuing surveys of the needs, interest, attitudes, knowledge, and behavior of the American public regarding health. The Secretary shall use the findings of such surveys and the findings of similar surveys conducted by national health education organizations and community health education organizations as a basis for formulating policy respecting health education and promotion and preventive medicine. For the surveys to be conducted through the National Center for Health Statistics there are authorized to be appropriated $3,000,000 for fiscal year 1976, $4,000,000 for fiscal year 1977, and $5,000,000 for fiscal year 1978.

(b) (1) The Secretary, acting through the division for community health education programs, shall support and encourage new and innovative programs in health education and preventive medicine and shall specifically—

(A) support demonstration programs, including training, in health education, health promotion, and preventive medicine, which programs (i) are within hospitals, ambulatory care settings, and other appropriate settings representative of broad cross sections of people, (ii) focus on objectives that are measurable, and (iii) emphasize the prevention or moderation of illness or accidents that appear controllable through individual behavior;

(B) provide consultation to organizations that request help in planning or evaluating health education programs;

(C) develop health education and preventive medicine model curriculums for medical, dental, and nursing schools, schools of public health, and other institutions engaged in training health professionals; and

(D) establish continuing education and workshop programs to disseminate the most recent research findings in the field.

(2) The Secretary may not approve an application of any health care facility for a grant or contract under the Public Health Service Act or the Community Mental Health Centers Act for a fiscal year beginning after the date of enactment of this Act unless the application contains or is supported by assurances satisfactory to the Secretary that, during the period for which the assistance applied is to be made available, the applicant will provide such consumer health education for individuals receiving inpatient or outpatient services through such health care facility as the Secretary shall by regulation prescribe. The Secretary shall by regulation—

(A) require as a condition of eligibility to receive payments under title XVIII of the Social Security Act on and after ninety days after the date of enactment of this Act that a provider of services provide such consumer health education, and

(B) require as a condition to the receipt of payments under title XIX of the Social Security Act with respect to expenditures for any calendar quarter beginning more than ninety days after the date of the enactment of this Act that a State have in effect an agreement with the Secretary under which the State will require health care facilities located within its jurisdiction to provide such consumer health education.

(c) The Secretary, acting through the division for communications in health, education, shall establish a liaison between the Center and providers of health education services and the communications media. Such division shall be a clearinghouse for data on health information and education programs, including the materials used in such programs. The Secretary, acting through such division, shall—

(1) survey the existing health information data systems and, to the extent practicable, establish a connection with them; encourage further development of existing data systems; support the development of new ones where needed; and work to coordinate the efforts of all major groups involved in health information data systems;

(2) make health information available to the public and to organizations involved in health education;

(3) continually evaluate the effectiveness of existing

health information and health education services to enhance their scope and quality;

(4) encourage testing and expert evaluation of health information materials produced by others;

(5) bring together the major national health educational organizations to share ideas, to identify gaps and overlaps in health education programs and research, and to find ways in which the organizations can cooperate to make efforts more effective;

(6) find ways in which the communications media and the Center can cooperate to provide the best possible service programing in health education;

(7) seek ways of promoting more positive general public health education programs and of reducing misleading advertising and other health-threatening behavior in communications programs designed for children and general family consumption; and

(8) establish the Center as a source of information and expertise which can be used in planning and creating both commercial and noncommercial material in health education.

(d) The Secretary, acting through the division for Federal programs, shall—

(1) make recommendations to the Congress for

the inclusion in appropriate legislation of provisions respecting health education and promotion;

(2) establish a liaison with other Federal agencies engaged in health education and promotion, including the Office of Education, the Consumer Product Safety Commission, the Department of Agriculture, the Environmental Protection Agency, the National Institute for Occupational Safety and Health, the Department of Transportation, and the Department of Defense; and

(3) identify Federal programs and actions which are not in the interest of public health and determine methods for reviewing and commenting on such programs and actions.

INTERDEPARTMENTAL COMMITTEE ON HEALTH EDUCATION AND PROMOTION

SEC. 114. There is established a committee to provide for the communication and exchange of information necessary to promote and maintain the coordination and effectiveness of Federal programs and activities which relate to health education and promotion. The Secretary shall be the chairman of the committee and the President shall appoint as members of the committee the heads of Federal departments and agencies engaged in health education activities.

ADVISORY COUNCIL

SEC. 105. (a) There is established the Health Education and Promotion Advisory Council (hereafter in this section referred to as the "advisory council") which shall consist of nineteen members appointed by the Secretary. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who have distinguished themselves in the fields of medicine (including preventive medicine), dentistry, health education, epidemiology, the social and behavioral sciences, nutrition, and the provision of health services; persons who are representative of the interests of the general public (including representatives of business, labor, and consumer groups); and persons from government. Each member shall hold office for a term of four years, except that the Secretary may stagger the terms of members first appointed to the advisory council, and any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. The Secretary may, at the request of the Director, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members (other than members who are officers or employees of the United States) of the advisory council or of such committees shall be entitled to receive for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the advisory council or committee compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business each member may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Council shall meet as frequently as the Secretary deems necessary. Upon request of five or more members, it shall be the duty of the Secretary to call a meeting of the advisory council.

(b) It shall be the function of the advisory council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to the functions of the Center. The advisory council shall make an annual report to the Secretary and to the Congress on the performance of its functions, including any recommendations it may have with respect thereto.

(c) The advisory council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the advisory council such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare, as the advisory council may require to carry out its functions.

REPORTS

SEC. 106. (a) The Secretary shall make an annual report (not later than December 1 of each year) to the Congress on the activities and policy recommendations of the divisions of the Center.

(b) The Secretary, acting through the Center, shall assemble and submit to the President and the Congress not later than December 1 of each year—

(1) a report of the activities, findings, and recommendations of each of the divisions of the Center, and

(2) recommendations, based on the findings and recommendations of the divisions of the Center, for legislation and administration action within the executive branch.

AUTHORIZATION OF APPROPRIATIONS

SEC. 107. To carry out this title there are authorized to be appropriated $35,000,000 for fiscal year 1976, $40,000,000 for fiscal year 1977, and $45,000,000 for fiscal year 1978.

TITLE II—INSTITUTION FOR HEALTH EDUCATION AND PROMOTION

CONGRESSIONAL DECLARATION OF POLICY

SEC. 201. The Congress finds and declares that—

(1) it is in the public interest to inform the public about health and about ways to best protect and improve personal health;

(2) the public must develop the ability to examine and weigh consequences of personal decisions respecting health;

(3) the public must be motivated to desire changes supportive of more healthful lifestyles;

(4) impediments that inhibit the voluntary adoption and maintenance of more healthful practices by the public must be identified and mitigated or removed;

(5) to achieve these goals it is necessary for the Federal Government to complement, assist, and support a national policy that will advance the national health, reduce preventable illness, disability, and death, moderate self-imposed risks, and promote progress and scholarship in consumer health education and preventive medicine; and

(6) a private corporation should be created to facilitate the development of a health education and promotion strategy for the Nation.

ESTABLISHMENT OF CORPORATION

SEC. 202. There is authorized to be established a nonprofit corporation to be known as the "Institution for Health Education and Promotion" (hereafter in this title referred to as the "Institution") which will not be an agency or establishment of the United States Government. The Institution shall be subject to the provisions of this title and, to the extent consistent with this title, to the District of Columbia Nonprofit Corporation Act.

BOARD OF DIRECTORS

SEC. 203. (a) The Institution shall have a Board of Directors (hereafter in this title referred to as the "Board") consisting of twenty-five members appointed by the President, by and with the advice and consent of the Senate.

(b) The members of the Board (1) shall be selected from among citizens of the United States (not regular full-time employees of the United States) who are eminent in such fields as, and represent, health education, health care services delivery, nutrition, general education, consumer representation and advocacy, communications, labor and business, planning and organizational management, and public and private finance, and (2) shall be selected so as to provide as nearly as practicable a broad representation of various regions of the country and of various kinds of skills and experiences appropriate to the functions and responsibilities of the Institute.

(c) The members of the Initial Board shall serve as incorporators and shall take whatever actions are necessary to establish the Institution under the District of Columbia Nonprofit Corporation Act.

(d) The term of office of each member of the Board shall be four years; except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; (2) the terms of office of members first taking office shall begin on the date of incorporation and shall expire, as designated at the time of their appointment, nine at the end of one year, eight at the end of two years, and eight at the end of four years; and (3) a member whose term has expired may serve until his successor has qualified. No member shall be eligible to serve in excess of two consecutive terms of four years each.

(e) Any vacancy in the Board shall not affect its power, but shall be filled in the manner in which the original appointments were made.

(f) The President shall designate one of the members first appointed to the Board as Chairman; thereafter the members of the Board shall annually elect one of their number as Chairman. The members of the Board shall also elect one or more of them as a Vice Chairman or Vice Chairmen.

(g) The members of the Board shall not, by reason of such membership, be deemed to be employees of the United States. They shall, while attending meetings of the Board or while engaged in duties related to such meetings or in other activities of the Board, be entitled to receive compensation at the rate of $100 per day including traveltime, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, equal to that authorized by law (5 U.S.C. 5703) for persons in the Government service employed intermittently.

OFFICERS AND EMPLOYEES

SEC. 204. (a) The Institution shall have a President, and such other officers as may be named and appointed by the Board for terms and at rates of compensation fixed by the Board. No individual other than a citizen of the United States may be an officer of the Institution. No officer of the Institution, other than the Chairman and any Vice Chairman, may receive any salary or other compensation from any source other than the Institution during the period of his employment by the Institution. All officers shall serve at the pleasure of the Board.

(b) No political test or qualifications shall be used in selecting, appointing, promoting, or taking other personnel actions with respect to officers, agents, and employees of the Institution.

NONPROFIT AND NONPOLITICAL NATURE OF THE INSTITUTION

SEC. 205. (a) The Institution shall have no power to issue any shares of stock or to declare or pay any dividends.

(b) No part of the income or assets of the Institution shall inure to the benefit of any director, officer, employee, or any other individual except as salary or reasonable compensation for services.

(c) The Institution may not contribute to or otherwise support any political party or candidate for elective public office.

FUNCTIONS

SEC. 206. To facilitate the development of a health education and promotion strategy for the Nation the Institution shall carry out the following functions:

(1) CONSENSUS BUILDING AND POLICY DETERMINATION.—The Institution shall establish communications with, provide a forum for the involvement of, and seek the advice and support of, organizations, agencies, and groups involved in health care, education, labor and business, social and civic organizations, consumer organizations, and

communications. The Institution shall review and analyze the need, and resources available, for health education and promotion and the effect of alternative health education methods and procedures on health status to determine which methods and procedures offer the best opportunities for improving the Nation's health. Specifically, the Institution shall—

(A) provide a private focal point for the coordination of a structured national exchange on health education issues and problems involving all of the various concerned disciplines and interests;

(B) identify and express the superordinate health education policies and guides to which many different organizations, agencies, and groups can subscribe and incorporate voluntarily into their own health education efforts;

(C) stimulate, sponsor, coordinate, and support the development of new health education initiatives and programs in which many organizations and agencies can participate;

(D) develop national policy recommendations which are supportive of long-range preventive approaches to national health improvement and which emphasize the support and maintenance of normal growth and development as the foundation for disease prevention; and

(E) provide a forum for nongovernmental organizations to participate in comprehensive national planning, action, and evaluation of health education efforts.

(2) NATIONAL STRATEGY DESIGN.—The Institution shall coordinate and stimulate a variety of projects involving other organizations, agencies, and groups to develop such strategy designs or design components as are required to increase the appropriateness, acceptability, and effectiveness of health education efforts nationwide. In the performance of this function, the Institution shall—

(A) in order to indicate directions for improving the Nation's health, develop a perspective and definition of the role of health education, its placement in the health and education systems, and its relationships to disease prevention and general health maintenance practices;

(B) review, analyze, and summarize the nature, scope, magnitude, and dimensions of unmet consumer health education needs and identify the critical gaps or deficiencies in personal preventive practices, in the use of health and related social services, and in programs to improve social and environmental conditions and other conditions affecting health care and education;

(C) review, analyze, and assess the state of health education theory and practices in relation to identified consumer needs and identify the possibilities for the development of new or improved technologies and practices;

(D) identify the types and availability of the resources required to meet priority consumer needs; and

(E) develop action plans for the development or increased allocation of resources required to produce significant results in meeting consumer health education needs.

(3) HEALTH EDUCATION ADVOCACY.—The Institution shall assist in stimulating, developing, implementing, and assessing a total communications program utilizing a full range of media available to reach diversified groups in order to increase national understanding and support for the value of health education and the role each citizen and every organization, institution, and agency can and should play to improve individual, community, and, ultimately, the national health through educational means. In performance of this function, the Institute shall—

(A) be an active participant in the efforts of organized elements at all levels in the health and educational systems and work with all interested organizations, agencies, and groups to assist in the development of more concerted, cooperative approaches to meeting consumer needs;

(B) publicize the latest information on technological developments in health education and on effective health education practices;

(C) develop opportunities which will enable consumer's and citizen's groups to become effective advocates for health education in their communities; and

(D) publicize and work with other public or private organizations, agencies (including the Center), and groups to secure widespread endorsement and implementation of the Institution's policies and recommendations.

(4) TECHNICAL ASSISTANCE.—The Institution shall assist in accelerating the incorporation of improved technology into health education practice by establishing a system of technical assistance and training and by making available the expertise of other cooperating organizations, as well as its own staff, in response to the needs of National, State, and local groups for assistance in improving the planning, implementation, and evaluation of their health education programs. In the performance of this function, the Institution shall—

(A) identify individuals with specialized skills, knowledge, and experience for involvement in the Institution's policy and strategy functions, for work on specialized projects, and for response to external requests for assistance;

(B) develop a cadre of consultants and trainers and establish mechanisms for their use by organizations, agencies, and groups requesting the Institution's assistance;

(C) stimulate and assist in the development and provide practical and tested models, instruments, and procedures for health education program planning and assessment, for training of health education providers, and for consumer and community involvement in the planning, implementation, and evaluation of health education strategies and programs; and

(D) identify information, training, research, and planning deficiencies generally current in health education practices and develop programs or projects for the correction of such deficiencies.

(5) EVALUATION, TESTING, AND DEMONSTRATION.—The Institution shall encourage the development and utilization of valid and acceptable research and evaluation methods for a wide variety of health education programs and technologies. It shall develop coalitions and consortium arrangements with other organizations and agencies for cooperative efforts in model design and testing and for joint sponsorship and exchange of information on comparable research and evaluation projects. In the performance of this function, the Institution shall—

(A) stimulate and support the development of valid techniques and strategies to measure the appropriateness, acceptability, and effectiveness of the process and outcomes of experimental and demonstration health education projects;

(B) establish mechanisms for continuing communication concerning program test experience, modifications, and evaluation;

(C) analyze, summarize, and disseminate information regarding experience of diversified applications of recommended models, components, and evaluation approaches; and

(D) selectively field test measures, instruments, techniques, and model components as required for Institute strategy design activities.

ADVISORY PANEL

SEC. 207. The Board shall appoint an advisory panel comprised of two hundred individuals with appropriate competencies and abilities. The principal function of the advisory panel shall be to provide advice for members of the Board. Additionally, it shall serve as a primary source for appointments to special committees, task forces, and conferences. The advisory panel shall receive all Institution reports.

REPORT TO CONGRESS

SEC. 208. The Institution shall submit an annual report to the President for transmittal to the Congress. The report shall include a comprehensive and detailed report of the Institute's operations, activities, financial condition, and accomplishments under this title and may include such recommendations as the Institute deems appropriate.

FINANCING

SEC. 209. There are authorized to be appropriated for expenses of the Institution $1,000,000 for fiscal year 1976; $3,000,000 for fiscal year 1977; and $5,000,000 for fiscal year 1978.

RECORDS AND AUDIT

SEC. 210. (a) The accounts of the Institution shall be audited annually in accordance with generally accepted auditing standards by independent certified public accountants or independent licensed public accountants certified or licensed by a regulatory authority of a State or other political subdivision of the United States. The audits shall be conducted at the place or places where the accounts of the Institution normally are kept.

(b) The report of each such independent audit shall be included in the annual report required by section 208. The audit report shall set forth the scope of the audit and include such statements as are necessary to present fairly the Institution's assets and liabilities, surplus or deficit, with an analysis of the changes therein during the year, supplemented in reasonable detail by a statement of the Institution's income and expenses during the year, and a statement of the sources and application of funds, together with the independent auditor's opinion of those statements.

94TH CONGRESS
1ST SESSION

H. R. 7050

IN THE HOUSE OF REPRESENTATIVES

MAY 15, 1975

Mr. STAGGERS (for himself and Mr. DEVINE) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

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A BILL

To extend appropriations authorizations for communicable disease and other control programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Control Programs Amendments of 1975".

COMMUNICABLE DISEASE AND OTHER CONTROL PROGRAMS

SEC. 2. (a) Section 317 of the Public Health Service Act is renumbered as 315 and is amended to read as follows:

"COMMUNICABLE DISEASE AND OTHER CONTROL PROGRAMS

"SEC. 315. (a) The Secretary may provide technical assistance to appropriate public authorities and scientific institutions for activities concerned with control programs.

"(b) The Secretary may make grants to States and, in consultation with the State health authority, to agencies and political subdivisions of States to assist in meeting the costs of control programs. In making a grant under this section, the Secretary shall give consideration to (1) the relative extent, in the area served by the applicant for the grant, of the problems with which the applicant's control programs are concerned, and (2) the design of the applicant's control programs.

"(c) (1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Except as provided in paragraph (2), such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(2) An application for a grant shall—

"(A) set forth with particularity the objectives (and their priorities, as determined in accordance with such regulations as the Secretary may prescribe) of the applicant for each of the programs he proposes to conduct with assistance from a grant under this section, and

"(B) provide for the reporting to the Secretary of such information as he may require concerning (i) the problems, in the area served by the applicant, with which the control programs are concerned, and (ii) the control programs of the applicant.

"(3) Each recipient of a grant under this section shall keep such records as the Secretary shall prescribe including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant was given or used and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(4) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of grants under this section that are pertinent to such grants.

"(5) Nothing in this section shall be construed to require any State or any agency or political subdivision of a

State to have a venereal disease control program which would require any person who objects to any treatment provided under such a program to be treated or to have any child or ward of his treated under such a program.

"(6) All information obtained in connection with the examination, care, or treatment of any individual under any program which is being carried out with a grant made under this section shall not, without such individual's consent, be disclosed except as may be necessary to provide service to him. Information derived from any such program may be disclosed—

"(A) in summary, statistical, or other form, or

"(B) for clinical or research purposes,

but only if the identity of the individuals diagnosed or provided care or treatment under such program is not disclosed.

"(d) (1) Payments under grants under this section may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of this section.

"(2) The Secretary, at the request of a recipient of a grant under this section, may reduce such grant by the fair market value of any supplies (including vaccines and other preventive agents) or equipment furnished to such recipient and by the amount of the pay, allowances, travel expenses, and any other costs in connection with the detail of an officer or employee of the Government to the recipient when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such recipient and for the purpose of carrying out the programs with respect to which the grant under this section is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, but such amount shall be deemed a part of the grant to such recipient and shall, for the purposes of paragraph (1) of this subsection, be deemed to have been paid to such agency.

"(e) The Secretary shall submit to the President for submission to the Congress on March 1 of each year (1) a report on (A) the extent of controllable diseases, lead-based paint poisoning, and infestation by rats, and (B) the effectiveness of (i) activities assisted under grants under this section, and (ii) all Federal and other public and private activities, in controlling these problems, and (2) a plan for the coming fiscal year for the control of these problems.

"(f) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to an agency or a political subdivision of a State under other provisions of Federal law and which are available for the conduct of control programs from being used in connection with programs assisted through grants under this section.

"(g) For purposes of this section, 'control programs' are programs designed and conducted to control communicable and other diseases, lead-based paint poisoning, or infestation by rats.

"(h) For purposes of this section, 'lead-based paint' means paint containing any lead.

"(i) For purposes of this section, 'State' includes territories and possessions of the United States.

"(j) There are authorized to be appropriated $34,000,000 for the fiscal year ending June 30, 1976, and for each of the two succeeding fiscal years, for grants under this section.".

(b) Section 318 is repealed.

(c) Section 319 is renumbered as 316.

(d) Section 503 (a) of the Lead-Based Paint Poisoning Prevention Act is amended by adding at the end the following new sentence: "Sums appropriated under section 315 of the Public Health Service Act shall be available for the period beginning July 1, 1976, and ending September 30, 1978, to continue assisting private nonprofit organizations in developing and carrying out programs for which grants were made under title I of this Act for the fiscal year 1975.".

EFFECTIVE DATE

SEC. 3. This Act shall take effect on July 1, 1975.

[H.R. 3205, introduced by Mr. Cohen (for himself and Mr. Hastings) on February 19, 1975, and

H.R. 5428, introduced by Mr. Cohen (for himself, Mr. Hastings, Mr. Brown of California, Mr. Dominick V. Daniels, Mr. Downey, Mr. Emery, Mr. Hicks, Mr. Pattison of New York, Mr. Railsback, Mr. Sarasin, Mrs. Spellman, Mr. Solarz, and Mr. Vigorito) on March 25, 1975,

are identical as follows:]

A BILL

To amend the Public Health Service Act to establish a Health Education Administration within the Department of Health, Education, and Welfare and to provide for the development and implementation of a national health education program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "National Health Education Policy and Development Act".

FINDINGS

SEC. 2. The Congress finds and declares that—

(1) the achievement of good health at a reasonable cost is a priority goal of the Federal Government;

(2) a number of health problems have their roots in the habits, lifestyles, attitudes, and beliefs of the American people;

(3) a sense of individual responsibility for personal health is an essential prerequisite to improved health quality and to improved health care in this country;

(4) strong health education programs can play an important role in helping the consumer (A) to understand his health and how to preserve it, (B) to understand the nature of various diseases, and (C) to make intelligent use of available health services;

(5) significant changes in consumer behavior regarding health care can occur with proper health education;

(6) there is a need for the development of effective school health education programs; and

(7) responsibility for health education is fragmented since no single agency inside or outside of government is responsible for setting goals, maintaining criteria of performance, or measuring results.

ESTABLISHMENT OF A NATIONAL HEALTH EDUCATION PROGRAM

SEC. 3. The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE XVII—HEALTH EDUCATION

"PURPOSE

"SEC. 1701. It is the purpose of this title to develop a national health education policy and program, and to authorize financial assistance for the development and implementation of that policy, in order to discourage wasteful and inappropriate use and provision of health services, and thus to encourage the maximum benefits for the costs incurred.

"HEALTH EDUCATION ADMINISTRATION

"SEC. 1702. (a) There is established, within the Department of Health, Education, and Welfare, a Health Education Administration (hereafter in this title referred to as the 'Administration').

"(b) (1) The Administration shall be headed by the Administrator of the Health Education Administration (hereafter in this title referred to as the 'Administrator') who shall be appointed by, and who shall report directly to, the Secretary.

"(2) The Administrator shall be paid at a rate equal to the rate of basic pay in effect for level V of the Executive Schedule.

"ADVISORY COUNCIL

"SEC. 1703. (a) There is established a permanent Advisory Council for Health Education (hereafter in this title referred to as the 'Council') to advise, consult with, and make recommendations to, the Administrator on matters relating to the administration of this title.

"(b)(1) The Council shall be composed of thirteen members as follows:

"(A) The Assistant Secretary of Health, Education, and Welfare for Health.

"(B) The Assistant Secretary of Health, Education, and Welfare for Education.

"(C) The Director of the Office of Consumer Affairs.

"(D) Ten members appointed by the Secretary.

"(2) The appointed members of the Council shall include—

"(A) two physicians with expertise in preventive medicine, the practice of family medicine, community medicine, or public health;

"(B) two health professionals (other than physicians) who are involved in providing preventive health services to patients;

"(C) one person who is engaged in teaching health professionals, or in developing curriculum for the teaching of health professionals, in the area of community medicine, preventive medicine, or social medicine;

"(D) one behavioral scientist with expertise in the dissemination of educational information respecting health to the general public;

"(E) two persons representing the health insurance industry; and

"(F) two persons knowledgeable in consumer affairs who are not health professionals, health educators, representatives of the health insurance industry, or in any other way associated with providing health services to the public.

"(c) (1) Except as provided in paragraph (2), each appointed member of the Council shall hold office for a term of four years.

"(2) (A) Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term.

"(B) Of the first ten appointed members of the Council—

"(i) five shall be appointed for a term of two years, and

"(ii) five shall be appointed for a term of four years,

with the Secretary designating the term of each such member at the time of the appointment of such member.

"(d) Appointed members of the Council shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Council; and while away from their homes or regular places of business in the performance of services for the Council, all members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code.

"STUDY

"SEC. 1704. The Administrator shall conduct a study and investigation of—

"(1) the current status of health education in the United States;

"(2) the cost benefits of health education programs as compared to other health service programs;

"(3) existing and proposed Federal, State, and local health education programs;

"(4) factors bearing upon a consumer's motivation for preserving his own health and utilizing health services;

"(5) areas of greatest potential impact for health education, particularly as related to (A) personal health care and resource utilization, (B) the ability of health professionals to interact with their patients with respect to preventive health care measures, and (C) the transformation of epidemiologic, clinical, and laboratory knowledge of health problems into effective practical programs for health maintenance and health education;

"(6) potential locations for programs of health education, including schools, worksites, and health care facilities;

"(7) opportunities to improve, by means of health education, the well-being of ethnic, economic, geographic, cultural, and other identifiable groups which have distinctive health problems; and

"(8) such other subjects relating to health education as the Administrator deems appropriate.

The Administrator shall complete such study and investigation within the one-year period beginning on the date of enactment of this title.

"GRANTS

"SEC. 1705. (a) The Administrator upon the recommendation of the Council is authorized to make grants to public or nonprofit private entities and may enter into contracts with public or private entities for the purpose of developing or evaluating specific educational and informational techniques for the dissemination of health information, including but not limited to the following:

"(1) A toll-free telephone system with recorded tapes or other methods to provide health consumers with information on public health services available to them, crisis information, and the means to obtain health related publications.

"(2) The publication of information, to be updated annually, pertaining to the individual's ability to improve and safeguard his own health, including reports accompanied by suitable illustrations on dental health, disease control, environmental health, family life and human development, nutrition, safety and accident prevention, smoking and health, drug abuse, alcoholism, consumer health, venereal disease, and other reports which in the opinion of the Administrator are specially suited to interest and instruct the health consumer.

"(3) Health education curriculums to be used in classroom settings, including materials directed at specific age, income, cultural, and geographic populations.

"(4) Public service advertisements and programs provided through the media, including newspaper, radio, and television.

"(5) Methods for training individuals in the development, production, and dissemination of the various types of techniques referred to in paragraphs (1), (2), (3), and (4) of this subsection and means of providing for the continuing education of such individuals.

"(b) (1) The Administrator, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private entities for the purpose of developing multifaceted systems of health care education for a defined geographic region pursuant to and in accordance with those established under section 301 of title 42, United States Code. In awarding such grants the Administrator shall, to the extent practicable, assure an equitable geographic and demographic distribution without regard to the amount of the grant.

"(2) Projects assisted under this subsection shall—

"(A) utilize in a coordinated manner all such techniques, including techniques described in subsection (a) of this section, as may be appropriate to provide effective health education services to the population of the applicable region; and

"(B) evaluate the effectiveness of each particular technique utilized to identify its particular advantages or disadvantages.

"(c) The Administrator, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out health education programs described in section 1705 (a) and (b).

"(d) No grant may be made under this section unless an application for such grant has been submitted to, and approved by, the Administrator. Any such application shall be in such form, shall be submitted to the Administrator in such manner, and shall contain such information as the Administrator may by regulation require.

"REPORTS

"SEC. 1706. (a) (1) The Administrator, after consultation with the Council, shall submit an annual report to Congress and the Secretary on the status of health education in the United States. Each such report shall include—

"(A) a statement of the activities carried out under this title during the preceding year and the extent to which each such activity achieves the purposes of this title;

"(B) a statement of the activities intended to be carried out during the succeeding year, including an estimate of the cost of such activities;

"(C) an assessment of the manpower needs to carry out health education programs in the States and a statement describing the activities carried out under this title designed to prepare teachers and other personnel for such programs; and

"(D) such recommendations with respect to any legislation required for an expanded program of health education or for consolidation of existing health education and consultation programs as the Administrator deems appropriate.

"(2) Upon completion of the study and investigation required by section 1704, the Administrator shall submit to Congress and the Secretary a report containing a detailed statement of his findings and conclusions, together with such recommendations based on those findings and conclusions as the Administrator deems appropriate.

"(b) Whenever the Council disagrees with any aspect of any report submitted by the Administrator pursuant to subsection (a) or disagrees with any action taken by the Administrator under this title (including the making of any grant or the entering into of any contract under section 1705), it may submit to the Congress and the Secretary such reports as it deems appropriate with respect to such disagreement.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 1707. (a) For the purpose of making payments pursuant to grants or contracts authorized by section 1705, there are authorized to be appropriated such sums as may be necessary, except not to exceed $5,000,000 for the first fiscal year which begins after the date of enactment of this title, $10,000,000 for the second such fiscal year, and $15,000,000 for the third such fiscal year.

"(b) No funds appropriated under any provision of law other than subsection (a) of this section, excepting with respect to alcohol or drug abuse programs authorized under Public Law 93-282, Public Law 92-255, Public Law 93-422, may be used in any fiscal year described in subsection (a) to make payments pursuant to any grant or contract for any project respecting health education if—

"(1) section 1705 authorizes grants or contracts for such a project, and

"(2) all the funds authorized to be appropriated under subsection (a) of this section for that fiscal year have not been appropriated for, and obligated in, that fiscal year.".

[H.R. 4444, introduced by Mr. Rangel on March 6, 1975, and H.R. 10515, introduced by Mr. Florio on November 3, 1975, are identical as follows:]

A BILL

To extend authorization for appropriations for the Lead-Based Paint Poisoning Prevention Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 503 of the Lead-Based Paint Poisoning Prevention Act is amended by striking out "fiscal years 1974 and 1975" each place it appears in subsections (a), (b), and (c) and inserting in lieu thereof in each case "fiscal years 1974, 1975, 1976, and 1977".

I

U.S. Consumer Product Safety Commission,
Washington, D.C. July 21, 1975.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This letter is in response to your request for a report on H.R. 4444, a bill

"To extend authorizations for appropriations for the Lead-Based Paint Poisoning Prevention Act."

The bill would extend for two years authorizations for appropriations for programs under the Act at levels equal to those enacted for fiscal years 1974 and 1975.

While the Commission supports enactment of legislation extending authorizations for appropriations for the lead based paint programs conducted by the Departments of Health, Education, and Welfare and Housing and Urban Development, it defers to those agencies with respect to the appropriations of the specific amounts to be authorized by H.R. 4444.

Sincerely,

Constance B. Newman,
Vice Chairman.

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., December 5, 1975.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of July 21, 1975 for the views of this Office on H.R. 8278, a bill "To amend the Public Health Service Act to provide authority for health information, education, and promotion programs, to revise and extend the authority for disease prevention and control programs, and to revise and extend the authority for venereal disease programs."

In testimony before your Committee on November 3, 1975 and November 12, 1975, the Department of Health, Education, and Welfare explained its reasons for recommending against enactment of the health education provisions (Title I) and the disease prevention and control provisions (Title II) of H.R. 8278.

We concur in the views expressed by HEW in its testimony and, accordingly, recommend against enactment of H.R. 8278. In lieu of Title II, we recommend favorable consideration of H.R. 7050, the Administration's proposed "Control Programs Amendments of 1975." Enactment of H.R. 7050 would be in accord with the program of the President.

Sincerely,

James M. Frey,
Assistant Director for Legislative Reference.

Department of Health, Education, and Welfare,
Washington, D.C., December 18, 1975.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request for a report on H.R. 4444, a bill "To extend authorizations for appropriations for the Lead-Based Paint Poisoning Prevention Act."

We oppose enactment of H.R. 4444 because it would extend a separate, categorical grant authority, and recommend instead enactment of H.R. 7050, which would provide a single, integrated authority for disease and other control programs.

The bill would extend the appropriations authorizations in the Lead-Based Paint Poisoning Prevention Act through fiscal year 1977 at the authorization levels presently in the law for fiscal year 1975 ($25,000,000 for title I—Grants for the Detection and Treatment of Lead-Based Paint Poisoning; $35,000,000 for title II—Grants for the Elimination of Lead-Based Paint Poisoning; $3,000,-

000 for title III—Federal Demonstration and Research Program; Federal Housing Administration Requirements).

We recommend that the lead-based paint poisoning screening activities presently carried out under title I be continued, but under a general control programs authority. H.R. 7050, a bill which you introduced on behalf of the Administration, would provide such a general authority, and we recommend that H.R. 7050 receive favorable consideration by the Committee. The Department opposes continuation of separate, categorical grant authorities such as the one in title I; multiple categorical authorities cause considerable hardship on State and local health agencies trying to carry out well-balanced, effective prevention programs.

The Department objects to the extension of the title II appropriation authorization for grants for programs to eliminate the hazards of lead-based paint poisoning. Title II is not presently funded and the President's budget does not request funding for fiscal year 1976. Elimination of the hazards of lead-based paint poisoning is basically a local responsibility that should be addressed through local housing ordinances. The Federal role should continue to be that of limited research and demontration of new and effective techniques for hazard removal. We currently permit up to ten percent of project grant funds under title I to be used for abatement activities in emergency situations, and this has proved more than sufficient to meet such emergency needs.

We defer to the Department of Housing and Urban Development with respect to the desirability of extending the appropriation authorization for title III; the Department of Housing and Urban Development has primary responsibility for title III.

In summary, we oppose enactment of H.R. 4444 and recommend instead enactment of H.R. 7050.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program and that enactment of H.R. 7050 would be in accord with the program of the President.

Sincerely,

STEPHEN KURZMAN, *Secretary.*

Mr. ROGERS. Our first witness today is Mr. Gregory Ahart, the Director of the Manpower and Welfare Division of the General Accounting Office, Washington, D.C.

Mr. Ahart, we welcome you and your colleagues to the committee.

STATEMENT OF GREGORY J. AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY ROBERT V. FARABAUGH, ASSISTANT DIRECTOR, AND LAWRENCE GASTON, JR., SUPERVISORY AUDITOR, MANPOWER AND WELFARE DIVISION; AND HARRY E. BENCHOFF, SUPERVISORY AUDITOR, PHILADELPHIA REGIONAL OFFICE

Mr. AHART. Thank you.

I would like to introduce my associates at the table. On my left is Robert Farabaugh, Assistant Director of the Manpower and Welfare Division; on my right is Lawrence Gaston, Supervisory Auditor of the Manpower and Welfare Division, and Harry E. Benchoff, Supervisory Auditor of the Philadelphia Regional Office.

Mr. ROGERS. We welcome each of you.

Mr. AHART. We are pleased to appear here today to participate in your hearings on the extension of authority for disease prevention and control programs by discussing our report to the Congress—B164031 (5) dated September 29, 1975—on our review of the Federal urban rat control program.

Our review concerned HEW's Center for Disease Control in Atlanta, Ga., HEW's regional offices in Philadelphia, region III—and

Atlanta, region IV; and six rat control projects located in cities in five States.

The six projects reviewed were responsible for about 22 percent of the city blocks in Federal rat control target areas as of December 31, 1973, and had received almost 21 percent of the Federal grant funds during fiscal year 1974. These projects had reported 64 percent of their blocks to be in maintenance at December 31, 1973, as compared to the 34 percent average for the other 41 projects active at that time. We also sent questionnaires to all 47 rat control projects operating with fiscal year 1973 Federal grant funds, replies were received from 45.

SERIOUSNESS OF THE PROBLEM

HEW estimates there are 100 million rats in the United States—approximately one for every two citizens. Although rats bite more than 45,000 persons each year and create various health, economic, and psychological problems, their full impact has never been completely documented.

The incidence of reported death and illness from rodent-borne disease has generally been minimal during the past 5 years. However, failure to adequately control rodents could have serious consequences. Also, rats consume or contaminate quantities of food and feed and their gnawing and burrowing destroy other property. For example, the Board of Health of a large midwestern city impounds approximately $1 million worth of food each year because of rodent defilement. HEW has estimated that rats may cost the United States as much as $1 billion annually in direct economic losses. The psychological and social impact of rats cannot be measured financially.

THE FEDERAL GOVERNMENT'S ROLE

The Federal Government's involvement in an urban rat control program started with the enactment of the partnership for health amendments—Public Law 90-174, on December 5, 1967. This legislation amended section 314(e) of the Public Health Service Act (42 U.S.C. 246) to extend and expand the funding authorization for health services development project grants. Although not specifically authorized by the act, rat control activities were funded under this legislation.

From fiscal year 1969 when the initial rat control grants were first awarded, through fiscal year 1974, Government and private agencies have received approximately $85.4 million in Federal "seed" money to initiate or stimulate comprehensive rat control programs. Although the authorizing legislation for rat control project grants expired on June 30, 1974, the Congress has continued to provide rat control funds through a series of joint resolutions. In fiscal year 1975, $13.1 million was made available. The Presidential budget submission for fiscal year 1976 requests only $5.41 million. As of October 30, 1975, no fiscal year 1976 grants have been awarded.

PROGRAM GOALS

HEW's goal for the Federal urban rat control program is to reduce rat populations and alter conditions conducive to rat infestations, so that they no longer significantly affect the health and economy of the target area. HEW measures the program's progress by the reduction in the number of confirmed rat bites and by the increase in the number of city blocks in maintenance. Maintenance is attained when 2 percent or less of the premises on a target block exhibit exterior signs of active rat infestations and either:

(1) 15 percent or less of the premises have exposed garbage, or
(2) 30 percent or less of the premises have refuse storage which does not meet HEW's criteria.

Major emphasis is placed on improving the physical and social environment and on the "people aspect" of rat control—communicating with people, winning their cooperation and motivating them to properly maintain their environment. Projects are expected to implement comprehensive rat control programs focusing on permanent, long-range solutions.

Rat control project operations have three phases:

Pre-attack, which involves preliminary planning and community information efforts but no direct operational activities.

Attack, which involves comprehensive operations to rid the area of rats and conditions conducive to rats.

Maintenance, the program's apex, when the rat control goal has been reached and reduced resources and activities can sustain the condition.

Although some progress has been made, problems affecting the program not only impede further advances but may also negate some of the earlier gains. A city block may actually be in maintenance 1 week and out of maintenance the next week because of the rapidity with which environmental conditions can deteriorate. There are various reasons for this lack of environmental stability, including:

(1) insufficient funds for conducting all phases of operations;
(2) weak or difficult-to-enforce sanitation codes; and
(3) lack of community cooperation.

PROGRESS MADE

According to HEW reports, the program has achieved:

a reduction in number of rat bites. The number of confirmed rat bites in the 20 original projects cities dropped about 54 percent, from 710 to 330, between 1969 and 1973.

an increase in the number of blocks where rat control was considered effective. HEW's current criteria, which was adopted in 1973, shows that, while 28.7 percent of the target area blocks (33,253) were in maintenance in September 1972, about 45.5 percent of the targeted blocks (45,193) were in maintenance in June, 1974.

greater public and local government awareness and understanding of rat control concepts and procedures.

ACCOMPLISHMENT OF PROGRAM GOAL DOUBTFUL

Despite this progress, it is doubtful that the program goal will be accomplished. Significant program problems noted during our review follow.

HEW's funding policy for rat control grants is predicated, in part, on the expectation that rat control projects will reach target area maintenance within the first 5 years of operation. None of the 19 rat control projects in their 6th year of Federal funding has reported attaining maintenance in all target area blocks. Only 10 of the 19 projects had attained maintenance in 51 percent or more of the blocks in their target areas.

During our review we accompanied HEW regional representatives on inspections of randomly-selected blocks classified as being in maintenance by six projects. On the basis of our sample, we estimate that, at the time of the inspections, 1,847 of the 5,531 blocks or 33 percent could not be classified in maintenance. The percentage of blocks reported but not actually in maintenance at the time of our inspection ranged from 50 percent—648 blocks of 1,297 blocks—at one project to 13 percent—42 blocks of 318 blocks—at another.

HEW's current funding policy calls for:

(1) an initial attack phase lasting a maximum of 5 years with a recommended 10- to 15-percent annual reduction in funds after the second year of operation, and

(2) a subsequent 3-year maintenance phase with steadily declining support of 23, 34 and 50 percent respectively, from the 5th year funding level.

Overall, the non-Federal share of program funding increased from about 27 percent in 1969 to an estimated 59 percent in 1974. However, information we obtained showed that some grantees are not substantially increasing their local contributions as grants get older.

During the first 5 years of the program, the 15 grantees originally funded in 1969 contributed about 36 percent of the total funding for their projects; Federal grants constituted the remaining 64 percent. For their 6th year of funding, 14 grantees were not planning to totally offset reductions in Federal funds with corresponding increases in non-Federal support. Only one project anticipated an increase in non-Federal funds greater than its Federal grant decrease.

Other rat control grantees which by fiscal year 1974 should have started to replace Federal funds have not substantially done so. For example, CDC records showed that 6 of the 10 grantees going into their 3rd or 4th years of funding in fiscal year 1974 were not planning to offset decreases in Federal funds with corresponding increases in non-Federal support.

As previously stated, HEW measures success for the rat control program on the ability of rat control projects to achieve predetermined standards for active exterior rat signs, unapproved refuse storage, and exposed garbage. HEW guidelines for rat control projects, however, recognize other factors contributing to a rat population. Some of these are the presence of animal food; potential rat entries such as structural defects; signs of interior rat activity; and rat harborage conditions such as abandoned vehicles and appliances, lumber on the ground and uncut weeds and grass. These conditions, however, are not considered in determining maintenance.

During our monitored inspections of blocks in maintenance, HEW representatives making the inspections noted a number of these conditions. The frequency to which they were noted is shown on page 17 of our report.

In addition to the above problem areas, progress has been impeded by:

sanitation codes that were either inadequate or not being enforced and

the inability of most project managers to gain effective community support.

CONCLUSIONS

Controlling the conditions conducive to rat infestation, not exterminating individual rats is the key to a successful rat control program. In doing this, major emphasis must be placed on improving the physical and social environment through—

(1) Attaining community support;

(2) Implementing effective environmental sanitation programs; and

(3) Eliminating food, water, and harborage sources.

The inability of rat control projects to adequately deal with these situations has slowed the program's progress. Funding deficiencies have also hindered the program's effectiveness. Specific comments made by rat control project officials emphasizing the seriousness of the problems are included in our report.

We do not dispute the logic on which HEW funding policy is based However, absolute adherence to such a policy without assurance that alternative funding is being generated by non-Federal sources has created problems.

Also, the constraints which determine maintenance understate the true extent of actual or potential rat problems. To present a more realistic portrait of project progress and to provide HEW and the Congress with a better basis for evaluating accomplishments and making decisions regarding the program's direction, we believe the criteria for determining maintenance should be expanded to include all conditions conducive to rat infestation.

RECOMMENDATIONS

Our report recommends that the Secretary of HEW should require the Director, Center for Disease Control, to reassess the Center's role in funding urban rat control programs. Specifically, the Director needs to improve implementation of the seed money concept to make it more effective in promoting and maintaining urban rat control programs. He should make the annual award of Federal funds conditional on the grantee's firm commitment of financial support.

To improve performance and to adequately measure accomplishments, we are also recommending that the Secretary require the Director to—

Revise the criteria for establishing maintenance in target areas; and

Help rat control projects to (1) strengthen and enforce sanitation codes and (2) obtain optimum community support.

HEW'S COMMENTS

HEW essentially supports the concept that rat control programs developed with Federal grants should, in the long run, be sustained by State or local governments. However, HEW did not agree to obtain a grantee's firm commitment for a specific local financial support level before the annual Federal grant is awarded.

HEW agreed to provide technical assistance to States and local grantees to improve the effectiveness of sanitation codes and to help grantees develop techniques designed to increase community participation and support in achieving rat control objectives.

Although HEW considers the factors in the current criteria to be the most appropriate indicators of maintenance for the great majority of project areas, it informed us that interior infestation will be incorporated in the maintenance criteria in those areas where it is a major problem.

Mr. Chairman, this concludes our statement. We shall be happy to answer any questions that you or other members of the subcommittee may have.

[The GAO report referred to follows:]

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

The Urban Rat Control Program Is In Trouble

Center for Disease Control

Department of Health, Education, and Welfare

Although HEW has reported progress in the Nation's fight to control rats, problems affecting this federally supported program not only impede further advances but may also negate some of the earlier reported gains.

GAO's review of the program included six rat control projects located in cities in Georgia, Maryland, Pennsylvania, Tennessee, and Virginia.

MWD-75-90

SEPT. 29, 1975

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(5)

To the President of the Senate and the
Speaker of the House of Representatives

We reviewed the Urban Rat Control Program to ascertain whether Federal funds were being used effectively to reduce the health, economic, and psychological problems caused by rats in United States urban centers.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats
Comptroller General
of the United States

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ABBREVIATIONS

CDC	Center for Disease Control
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

THE URBAN RAT CONTROL PROGRAM IS IN TROUBLE

Center for Disease Control
Department of Health,
Education, and Welfare

DIGEST

The Urban Rat Control Program is in trouble. Although some progress has been made, problems affecting this federally supported program not only impede further advances but may also negate some of the earlier gains.

Progress

According to Department of Health, Education, and Welfare (HEW) reports, the program has achieved:

--A 54-percent reduction, from 710 to 330, in the annual number of confirmed rat bites in areas originally covered by the program. (See p. 4.)

--A steady increase in the number of city blocks, about 20,500 at June 30, 1974, where rat control was considered effective. (See p. 6.)

--Greater public and local government understanding of the rat problem and actions needed to solve it. (See p. 6.)

Problems

Despite this reported progress, accomplishment of the program goal is doubtful.

--Although the number of city blocks considered to have effective rat control has substantially increased, the overall achievement level falls far short of what was targeted. None of the 19 rat control projects in their sixth year of Federal funding has reported attaining maintenance in all target area blocks within the targeted 5-year operational period. (See p. 7.)

- --There are indications that rat control projects are unable to sustain reported achievements. (See p. 8.)

- --Many cities have reduced rat control efforts because grantees are not supplying the money needed to offset phased reductions in Federal support. (See p. 11.)

- --The criteria for measuring program accomplishments may understate current or potential rat problems in the target areas. (See p. 17.)

In addition, progress was impeded by

- --sanitation codes that were either inadequate or not being enforced (see p. 20) and

- --the inability of most project managers to gain effective community support. (See p. 21.)

Recommendations

The Secretary, HEW, should require the Director, Center for Disease Control, to reassess the Center's role in funding urban rat control programs.

The Director needs to improve implementation of the "seed" money concept to make it more effective in promoting and maintaining urban rat control programs. Specifically, he should make the annual award of Federal funds conditional on the grantee's firm commitment of financial support. (See p. 23.)

To improve program performance and to adequately measure accomplishments, the Secretary should also require the Director to

- --revise the criteria for establishing maintenance in target areas (see p. 23) and

- --help rat control projects to (1) strengthen and enforce sanitation codes and (2) obtain optimum community support. (See p. 23.)

Agency comments and unresolved issues

HEW supports the concept that rat control programs developed with Federal grants should, in the long run, be sustained by State or local governments. However, HEW did not agree to obtain a grantee's firm commitment for a specific local financial support level before the annual Federal grant is awarded. (See pp. 23 and 24.)

HEW agreed to provide technical assistance to States and local grantees to improve the effectiveness of sanitation codes and to help grantees develop techniques designed to increase community participation and support in achieving rat control objectives. (See p. 24.)

Other HEW comments will be found on page 24.

CHAPTER 1

INTRODUCTION

The rat, abounding in the inner city, has become a symbol of America's urban blight. Rats contaminate food with the filth they carry about, damage buildings with their gnawings, outrage or frighten many people whose paths they cross, and may even attack the young and the aged. Man, through indifference and carelessness in maintaining his environment, has perpetuated their existence, and only man can control them.

SERIOUSNESS OF THE PROBLEM

The Department of Health, Education, and Welfare (HEW) estimates there are 100 million rats in the United States--approximately 1 for every 2 citizens. Although rats bite more than 45,000 persons each year and create various health, economic, and psychological problems, their full impact has never been completely documented.

Rats transmit disease directly, by bite or by contaminating food with urine, feces, and filth, or indirectly, by way of rodent-borne fleas or mites. Diseases associated with rodents include plague, murine typhus, rat-bite fever, leptospirosis, and salmonella food poisoning. These diseases have occurred in the United States within the past 5 years; however, it is impossible to prove rats were the cause in each instance.

Although the incidence of reported death and illness from rodent-borne disease has generally been minimal during the past 5 years, failure to adequately control rodents could have serious consequences. Plague, for example, which once devastated Europe, Asia, and Africa but has not appeared to any great degree in this country since 1924, is well established in the rural rodent population of the western United States. Thus, were the diseased rodents to come into contact with urban rodents, the possibility exists that plague could be transmitted to populated areas. Rats bearing plague-carrying fleas were trapped on the outskirts of a major western city in 1971--evidence of the potential hazard.

Rats consume or contaminate quantities of food and feed, and their gnawing and burrowing destroy other property. For example, the board of health of a large midwestern city impounds approximately $1 million worth of food each year because of rodent defilement. HEW has estimated that rats may cost the United States as much as $1 billion annually in direct economic losses. The psychological and social impact of rats cannot be measured financially.

THE FEDERAL GOVERNMENT'S ROLE

On December 5, 1967, the Partnership for Health Amendments (Public Law 90-174) became law. This legislation amended section 314(e) of the Public Health Service Act (42 U.S.C. 246) to extend and expand the funding authorization for health services development project grants. Although not specifically authorized by the act, rat control activities were funded under this legislation as health services development projects.

HEW has administrative responsibility for the Federal Urban Rat Control Program which evolved from this legislation. The program, initially administered by HEW's Health Services and Mental Health Administration, became the administrative responsibility of HEW's Center for Disease Control (CDC) on July 1, 1973.

From fiscal year 1969, when the initial rat control grants were awarded, through fiscal year 1974, government and private agencies have received approximately $85.4 million in "seed" money to initiate or stimulate comprehensive rat control programs. Although the authorizing legislation for rat control project grants expired on June 30, 1974, the Congress has provided rat control grant funds until the end of fiscal year 1975 through a series of joint resolutions. At June 30, 1974, HEW was administering 41 rat control grants with 52 projects in 59 communities serving approximately 6.8 million residents. (See app. I for list of rat control grantees and projects receiving Federal funds as of June 30, 1974, and app. II for list of rat control grantees and projects no longer receiving Federal funds.)

PROGRAM GOALS

HEW's goal for the Federal Urban Rat Control Program is to reduce rat populations and alter conditions conducive to rat infestations, so that they no longer significantly affect the health and economy of the target area. HEW measures the program's progress by the reduction in the number of confirmed rat bites and by the increase in the number of city blocks in maintenance. Maintenance is attained when 2 percent or less of the premises on a target block exhibit exterior signs of active rat infestations and either (1) 15 percent or less of the premises have exposed garbage or (2) 30 percent or less of the premises have refuse storage which does not meet HEW's criteria.

Major emphasis is placed on improving the physical and social environment and on the "people aspect" of rat control--communicating with people, winning their cooperation, and motivating them to properly maintain their environment. Projects are expected to implement comprehensive rat control programs focusing on permanent, long-range solutions. Individual rat control projects are to include such elements as (1) providing health education and community outreach programs to educate residents in rat control and environmental sanitation, (2) encouraging residents to participate in block or neighborhood associations to improve community sanitation, (3) providing maximum employment and educational opportunities for target area residents, (4) promoting, developing, improving, and enforcing appropriate housing, rat control, and sanitation codes and ordinances, (5) establishing coordination with local health and housing departments and other local agencies related to rat control, (6) inspecting and ratproofing garbage storage and eliminating rat harborage from private and public premises, (7) providing intensive and diversified rat killing activities to supplement permanent control measures, and (8) establishing a self-evaluation system.

Rat control project operations have three phases:

--Preattack, involving preliminary planning and community information efforts but no direct operational activities.

--Attack, involving comprehensive operations to rid the area of rats and conditions conducive to rats.

--Maintenance, the program's apex, when the rat control goal has been reached and reduced resources and activities can sustain the condition.

CHAPTER 2

THE PROGRAM IS IN TROUBLE

The Urban Rat Control Program is in trouble. Although some progress has been made, problems affecting the program not only impede further advances but may also negate some of the earlier gains.

Controlling rats and the conditions conducive to rats is a continuing effort requiring the cooperation of all citizens. A city block may actually be in maintenance one week and out of maintenance the next because of the rapidity with which environmental conditions can deteriorate. There are various reasons for this lack of environmental stability, including (1) insufficient funds for conducting all phases of operations; (2) weak or difficult-to-enforce sanitation codes; and (3) lack of community cooperation.

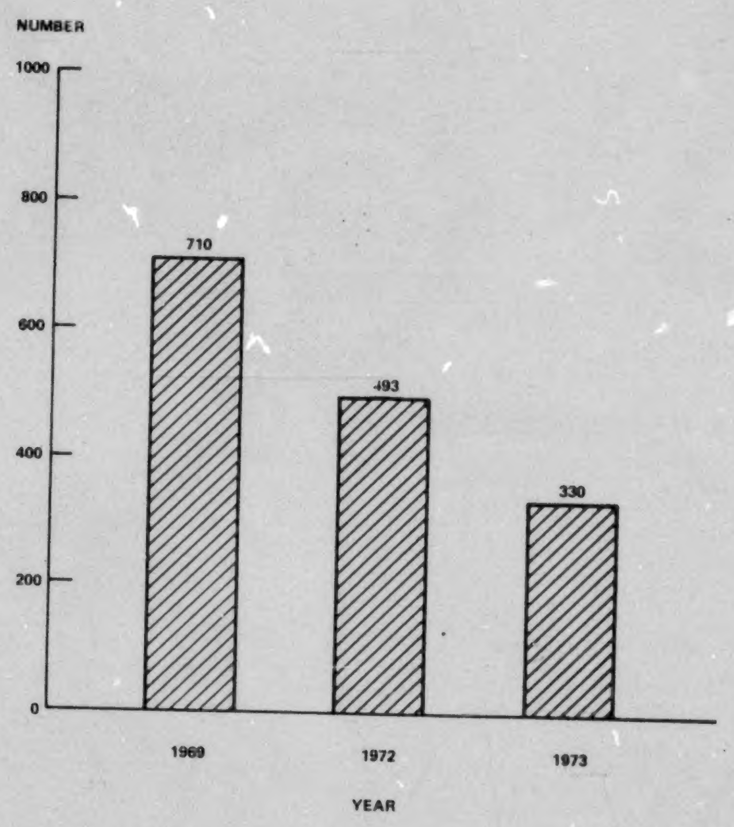
SOME PROGRESS HAS BEEN MADE

HEW obtains statistical data from each project on the number of (1) confirmed rat bites and (2) target area blocks classified in maintenance. Such data shows that rat control projects have had some success in accomplishing program goals.

Reduction in number of rat bites

Rat bites, besides causing physical injury which could lead to permanent disfigurement, cause psychological harm. They occur most commonly in crowded urban centers, in substandard housing, in areas with poor sanitation, or in neighborhoods where rat-infested buildings are being demolished.

According to HEW, the number of confirmed rat bites in the 20 original project cities dropped about 54 percent--from 710 to 330--between 1969 and 1973, as shown by the graph on the following page.



Increase of blocks in maintenance

Before April 1972, program accomplishments were measured by the decrease in the number of target area premises (1) showing exterior signs of active rat infestations such as burrows, tracks, feces, and gnawings and (2) having inadequate storage for garbage, rubbish, and other refuse. Data using these criteria show that the program initially achieved some success in the 20 original project city target areas, as shown on the following page.

Type of problem	Percentage of premises with problems 1969	1970	1971	1972	Percentage of decrease between 1969 and 1972
Exterior signs of active rat infestation	16	11	8	6	63
Unapproved refuse storage	63	57	51	46	27

In April 1972, HEW initiated a new method to measure program success. This method recognizes individual blocks reaching maintenance and provides a better basis for geographically determining problem areas.

Rat control projects first reported statistics using these criteria in September 1972. The progress reported since then is shown below.

Report period ending	Number of projects	Number of target area blocks	Number of target area blocks in reported maintenance	Percentage of target area blocks in maintenance
9-30-72	39	33,253	9,530	28.7
6-30-73	41	40,769	16,080	39.4
12-31-73	47	45,524	18,312	40.2
6-30-74	52	45,193	20,558	45.5

Other program accomplishments

According to HEW, the program has been successful in other ways. It has increased awareness and understanding of rat control concepts and the need for good sanitation habits by target area residents, some of whom participated in community and home improvement projects. Municipal officials in project cities have been made increasingly aware of the need to upgrade refuse storage and collection practices.

ACCOMPLISHMENT OF PROGRAM GOAL DOUBTFUL

Despite this progress, it is doubtful that the program goal will be accomplished because (1) although the number of blocks considered to have effective rat control has substantially increased, the overall achievement level falls far short of what was targeted; (2) there are indications that rat control projects cannot sustain reported achievements; (3) many cities are decreasing their rat control efforts because most grantees are not supplying the money needed to offset phased reductions in Federal support; and (4) the criteria for measuring program accomplishments may understate the actual or potential rat problems. In addition, sanitation codes that were either inadequate or not being enforced and the inability of most project managers to gain effective community support have impeded progress.

Rat control projects not reaching maintenance within targeted time

HEW policy for rat control grants is predicated, in part, on the expectation that rat control projects will reach target area maintenance within the first 5 years of operation. CDC officials said that this expectation had no technical basis but was based on an initial administrative decision to limit the funding for section 314(e) grants to 5 years. However, current policy calls for an additional 3 years funding after the projects reach maintenance.

None of the rat control projects receiving fiscal year 1974 Federal funds, and only one no longer receiving Federal funds, had reported attaining maintenance in all target area blocks within the initial 5-year operational period. The table below shows, as of June 30, 1974, the level of maintenance reached by the active rat control projects together with the number of years they were funded. Only 10 of the 19 projects in their sixth year of operation have attained maintenance in 51 percent or more of the blocks in their target areas.

Project year	Number of projects (note a)	Number of projects by percentage range of maintenance						Percent of total blocks in maintenance
		100	76-99	51-75	26-50	1-25	0	
1	6	-	-	-	-	-	6	-
2	9	-	2	-	-	3	4	27.9
3	10	-	-	5	2	2	1	38.8
4	3	-	-	1	1	1	-	40.9
5	5	-	1	-	1	2	1	43.2
6	19	-	3	7	7	1	1	57.3
Total	52	-	6	13	11	9	13	

a/Binghamton, N.Y., the only project to report reaching a 100-percent level of maintenance within its initial 5-year operational period, is not included because it was not funded during fiscal year 1974.

A CDC official said that some projects have been slow in attaining maintenance because the projects' target areas have been expanded from their initial size. The 45 respondents to a questionnaire we sent to the 47 rat control projects funded in fiscal year 1973 generally thought that they would probably not reach total maintenance within 5 years but that maintenance could probably be achieved in at least 65 percent of their target area blocks within this period. Most believed that, once reached, maintenance could probably be sustained.

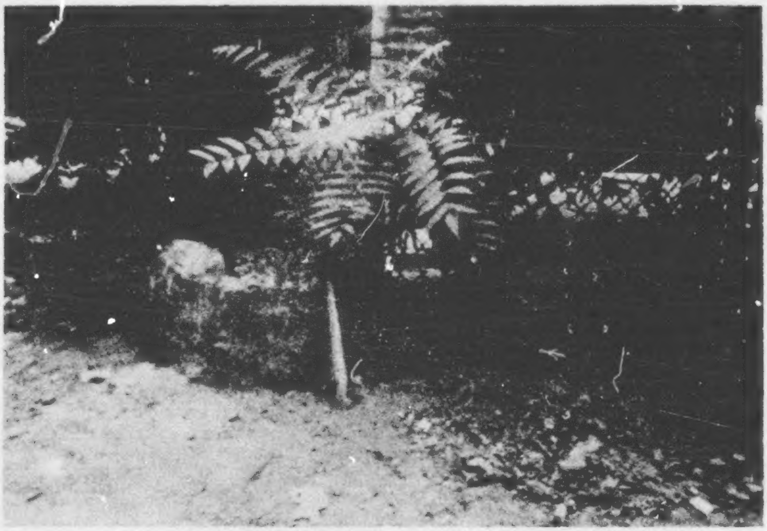
Reported progress not sustained

To ascertain if rat control projects were able to sustain maintenance, we accompanied HEW regional representatives on inspections of randomly selected blocks classified as being in maintenance by six projects. On the basis of our sample, we estimate that, at the time of the inspections, 1,847 of the 5,531 blocks, or 33 percent,1/ could not be classified in maintenance because (1) more than 2 percent of the premises showed exterior signs of active rat infestations or (2) the blocks exceeded HEW-prescribed limits for both unapproved refuse storage and exposed garbage. The percentage of blocks reported but not actually in maintenance at the time of our inspection ranged from 50 percent--648 blocks of 1,297 blocks--at 1 project to 13 percent--42 blocks of 318 blocks--at another.

The following photographs illustrate the types of conditions observed during the inspections.

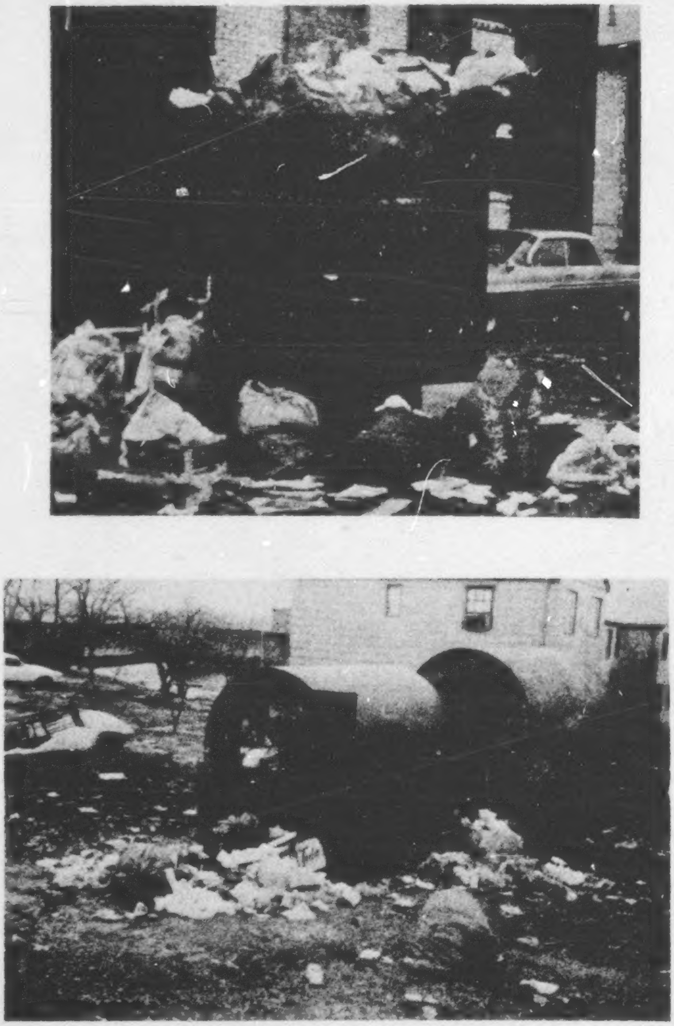
1/The estimated percentage of blocks not in maintenance is subject to a sampling error of 9.4 percent at the 95-percent confidence level. This means that, if all blocks reported to be in maintenance were inspected, the chances are 19 in 20 that the percentage of blocks found not to be in maintenance would be between 23.6 percent and 42.4 percent; i.e., 33 percent plus or minus 9.4 percent.

Exterior signs of rats--rat burrows underneath concrete slab



Exterior signs of rats--rat droppings outside of rat burrow

Unapproved refuse storage and exposed garbage



Regarding blocks which had at one time attained maintenance, project officials said that maintenance was very difficult to sustain without a concentrated and continued effort by the rat control project and the community residents. They generally stated that decreased funding has resulted in reduced manpower levels which has in turn resulted in less effort in all project functions including inspection, health education, and rat killing.

Decreasing efforts because of insufficient funding

Insufficient funding is one reason why federally funded rat control projects have been unable to reach and sustain maintenance. Project grants for urban rat control have been made available under section 314(e) of the Public Health Service Act since fiscal year 1969. These grants have always been viewed as stimulatory with a planned scaledown and eventual termination of Federal grant support to individual projects. Current funding policy calls for (1) an initial attack phase lasting a maximum of 5 years with a recommended 10- to 15-percent annual reduction in funds after the second year of operation and (2) a subsequent 3-year maintenance phase with steadily declining support of 23, 34, and 50 percent, respectively, from the fifth year funding level. As previously stated, this policy is based on an administrative decision.

HEW's policy statement for section 314(e) grants states that, "* * * grantees are expected to increase the proportion of support from non-Federal funds each year of the approved project period to ensure continuation of the program upon termination of Federal support." While no specific matching percentage is required for health services development project grants, grantees must assume some project costs and, in effect, be self-supporting after the presently contemplated 8-year Federal funding cycle.

Overall, the non-Federal share of program funding increased from about 27 percent in 1969 to an estimated 59 percent in 1974. However, information we obtained showed that some grantees are not substantially increasing their local contributions as grants get older.

During the first 5 years of the program, the 15 grantees originally funded in 1969 (see p. 12) contributed about 36 percent of the total funding for their projects; Federal grants constituted the remaining 64 percent. For their sixth year of funding, 14 grantees were not planning to totally offset reductions in Federal funds with corresponsing increases in non-Federal support. Only New Jersey was anticipating an increase in non-Federal funds during fiscal year 1974 greater than its Federal grant decrease.

The following chart shows the decrease in Federal funds from fiscal year 1973 to fiscal year 1974 and the estimated increase or decrease in non-Federal support for the 15 original grantees from the previous year.

Grantee	FY 1974 Federal rat control grant	Reduction in Federal grant funds between FYs 1973 and 1974	Estimated increase or decrease (-) in non-Federal support between FYs 1973 and 1974 (note a)
	(thousands)		
New Jersey State	$1,033.1	$424.4	$5,746.6
Philadelphia	1,716.4	585.1	540.8
Washington, D.C.	630.4	158.3	156.0
Baltimore	448.1	112.0	103.5
Mecklenburg Co., N.C.	30.4	51.4	49.9
Youth Pride, Inc., Wash., D.C.	88.5	26.4	16.7
Norfolk	62.8	20.9	7.3
Milwaukee	350.0	83.9	40.8
Cleveland	238.7	71.3	30.1
Nashville	232.3	109.3	53.3
Economic Opportunity Atlanta, Inc.	165.0	39.2	15.0
New York State	2,252.1	377.6	43.9
St. Louis	273.5	101.2	-42.5
Allegheny Co., Pa.	457.1	114.3	-99.2
Chicago	940.0	289.0	-155.6

a/Basis for figures obtained from CDC and HEW regional office records.

Other rat control grantees which by fiscal year 1974 should have started to replace Federal funds have not substantially done so. For example, CDC records showed that 6 of the 10 grantees going into their third or fourth years of funding in fiscal year 1974 were not planning to offset decreases in Federal funds with corresponding increases in non-Federal support.

Although State and local budgetary constraints have no doubt made input of non-Federal funds difficult for many grantees, rat control projects must obtain sufficient funding in order to have a successful program. However, if information obtained from the rat control projects typifies the overall problems involved in obtaining adequate non-Federal funding, the outlook for the program could be bleak. Below are some problems caused by inadequate funding.

--Although Philadelphia has steadily increased its local input for rat control activities, a project official said that because of inflation the combined city and Federal funding has become insufficient to meet the project's need. Another official stated that, because the city cannot totally fund the Philadelphia program, continual cuts in Federal funds will force the program to be more complaint oriented than comprehensive in nature.

--Nashville officials said that it has been extremely difficult to obtain local funds for rat control activities. Local input for the first 5 years has consisted of inkind contributions for office space and trucks to remove bulk trash items. During this time, local input reported to HEW averaged less than 9 percent of total program funding. Although scheduled to increase to almost 28 percent of total program funding in fiscal year 1974, the increase in local input will not replace lost Federal funds. While commenting on our report, the project director said that $50,000 in local cash funds were made available for program operations during 1975. Also, the director said that, if Federal funding is not continued, it is questionable if local funding would be adequate to maintain the project in the proper manner and, in that case, many areas would revert to their attack condition.

--Atlanta's contributions during the program's first 5 years averaged about 7 percent of total program funding. Scheduled to increase to almost 17 percent of total program funding for the sixth year of the grant, local input will not replace the Federal grant reduction for the sixth year. The privately operated Atlanta project has relied on the local government as its source of non-Federal funds. This support has been limited to inkind contributions for rat harborage removal. However, the project director is optimistic that local support will increase.

--Another sixth year project said in our questionnaire that "* * * The current trend in federal funding has been downward. There are insufficient local funds to make up for this deficit, especially in light of the present inflationary trends." Local contributions from this grantee have generally been declining and, for the sixth year of program funding, are not scheduled to replace lost Federal funds.

--A third year project said, "No local funds are available; both city and county will be laying off because of budgetary insufficiency due to the depressed local economy." Although this project has not mentioned any major problems, the experience of older projects makes future problems a distinct possibility.

A reduction in funding adversely affects a rat control project's operations, particularly if coupled with increasing costs. For example:

--Philadelphia has decreased its project's full-time personnel from about 375 employees in 1971, the peak year of Federal funding, to about 245 employees in 1974. A project official estimated 325 full-time employees are required for peak efficiency. Accordingly, Philadelphia (1) cannot make inspections at HEW-required levels, (2) has reduced the frequency of cleanup in target areas, and (3) has had to limit community education activities.

--Baltimore has reduced its full-time staff from 110 during the third year of Federal funding to 57 in its current (sixth) year of funding. Project officials estimate 90 employees working exclusively in the rat control target area are needed to bring all blocks into maintenance. As a result, (1) inspection frequency has declined, (2) the health education team has decreased from 10 employees to 1, (3) baiting and poisoning activity have been reduced from a 5 day a week intensive campaign to 2 days a week, and (4) the previous systematic rat control program has been replaced by a complaint-oriented system.

- --Norfolk's project has been reduced from 28 employees in peak year of operation to 18 employees in the current year. A project official estimated that 21 employees would insure maximum effectiveness. Norfolk has had to (1) limit distribution of educational materials, (2) eliminate inspection activities in designated low priority maintenance areas, (3) delay responding to complaints, and (4) defer needed expansion of the target area.

- --The 18 sixth year projects answering our questionnaire had reduced their staffs from 1,970 to 1,580 employees (20 percent) between 1971 and 1974. These totals include New York City, which increased its staff by approximately 200 employees during that period.

- --Many respondents, including all 18 sixth year projects, said that various services have been curtailed in their target areas because of decreased funding levels and increased operating costs. These cuts, classified from minor to serious, occurred in the following areas:

  - --Removal of rat harborage conditions.
  - --Community education.
  - --Inspection activities.
  - --Code enforcement activities.
  - --Baiting and poisoning activities.
  - --Followup on identified violations.
  - --Community sanitation activities.
  - --Response to rat complaints.

Our questionnaire asked whether the project's funding level was adequate. In analyzing responses to this question, we divided the projects into older projects--those in the fourth year of funding or older--and newer projects--those in the third year of funding or younger. Also, we classified those projects answering no problem, a minor problem, or a moderate problem as having no funding problem and those projects answering a substantial problem or a serious problem as having a funding problem.

As shown by the following table, a greater proportion of the older projects recognized and reported a funding problem. 1/

1/The probability that the response classifications were due to chance is less than 5 percent.

Relative age of projects	No problem with funding	Problems with funding	Total
Older projects	11	16	27
Newer projects	15	3	18
Total	26	19	45

HEW regional offices are responsible for approving grants to rat control projects within their regions. The anticipated non-Federal funding level is one factor they use in determining the funding levels. Although rat control program guidelines state that "projects will be given a higher priority for funding if they show a strong prospect for continuation when Federal support terminates," HEW regional and CDC officials said that non-Federal input is given the same consideration as any other factor in making final award decisions.

One HEW official said that grantees are made aware that local input is required as part of their grant obligation and that they are continually encouraged to increase local contributions. However, we found no grant termination because of failure to contribute non-Federal funds to the program although such a contingency is provided for in rat control program funding criteria.

HEW stated that approximately 80 percent of the current rat control projects have increased their local support since they were initially funded, although not by amounts equal to the decreases in Federal support. In addition, HEW stated, "In view of the severity of the rat problem in project cities, such failure to offset completely the reductions in Federal funding has not received overriding consideration in decisions to institute or continue Federal grant funding."

Criteria for measuring maintenance may understate problem

HEW measures success for the rat control program, i.e., maintenance, on the ability of rat control projects to achieve predetermined standards for active exterior rat signs, unapproved refuse storage, and exposed garbage.

HEW guidelines for rat control projects require, as part of the projects' overall inspection process, the recording of such problems as the presence of animal food; potential rat entries, such as structural defects; signs of interior rat activity; and rat harborage conditions, such as abandoned vehicles and appliances, lumber on the ground, and uncut weeds and grass. These conditions, however, are not considered in determining maintenance.

During our monitored inspections of blocks in maintenance HEW representatives making the inspections noted a number of these conditions, as shown in the table below and in the pictures on the following pages.

Number and Types of Conditions Found

Projects	Premises inspected	Animal food	Potential rat entries	Rat harborage: Abandoned automobiles and appliances	Rat harborage: Lumber on ground	Rat harborage: Other large rubbish	Rat harborage: Weeds and grass
Philadelphia	81	5	12	10	8	11	2
York	87	1	3	4	7	5	12
Baltimore	90	-	7	3	6	9	2
Norfolk	76	1	3	6	8	7	17
Atlanta	89	12	50	13	17	23	29
Nashville	90	-	23	11	19	17	14
Total	513	19	98	47	65	72	76

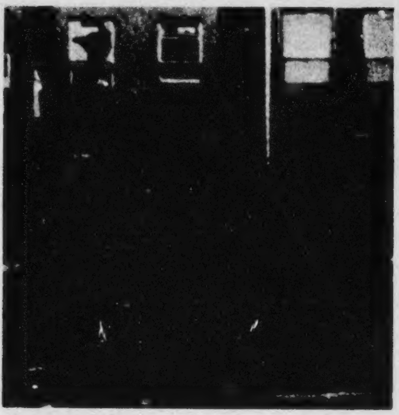
Despite the seriousness of many of these conditions, none could be considered a factor in determining whether an individual block was out of maintenance. In Philadelphia, for example, an HEW inspector advised the project director following our inspections that "* * * in looking at samples and numbers, we may say that a block is in maintenance. But when we see so many problems like dirty and inaccessible alleys, vacant buildings used as dumps, dogs, deteriorated housing, abandoned vehicles, dirty streets, etc., our judgment is defeated. A maintenance status under these circumstances has to be very unstable one." We question not only the stability of maintenance under these conditions, but also the existence of true maintenance in blocks evidencing such seemingly serious environmental deficiencies.

Rat control project officials offered us various opinions on the consideration of other factors in determining maintenance.

--A Philadelphia official thought HEW's criteria were not realistic for his project because its major rat problems were indoors. He said that Philadelphia was using a 5-percent active rat sign criterion, including the results of both interior and exterior inspections, rather than the HEW-mandated 2-percent exterior only criterion.

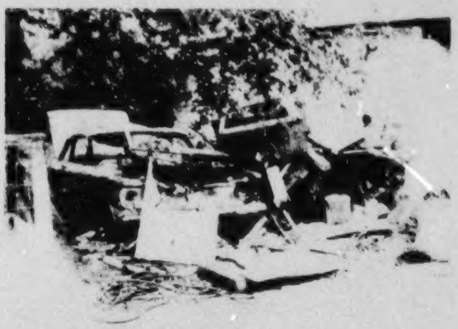
--A Norfolk project official thought HEW's criteria were unrealistic because they did not consider all conditions conducive to rat infestations. He suggested using a point system considering all environmental factors as a basis for computing maintenance.

Rat harborage condition--weeds and grass on maintenance block in Philadelphia

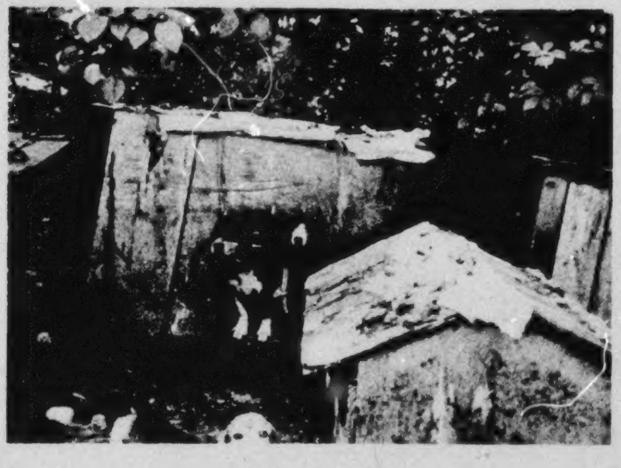


Rat harborage condition--lumber on ground on maintenance block in York

Rat harborage conditions--abandoned vehicle and large rubbish on attack block in York



Conditions supplying animal food to rats



--A York representative said HEW's maintenance criteria should, at the least, consider interior rat signs. As evidence of an interior rat problem in York, we visited 1 home, on a maintenance block, in which we were told project personnel trapped 18 live rats in the basement. Unless rat signs appear outside the house, this block will continue to be considered in maintenance under HEW's current criteria.

Forty-four of the 45 questionnaire respondents thought that these other conditions should be considered in computing maintenance, as shown by the following tabulation.

Condition	Number of respondents believing factor should be used in determining maintenance
Interior rat signs	28
Harborage conditions	34
Rat food (uneaten pet food or other food stuffs left out)	30
Potential rat entries (e.g., structural defects)	14
Number of reported rat bites	17

CDC officials said that, because HEW considers exterior rat signs, unapproved refuse storage, and exposed garbage to be the most important factors in establishing whether blocks are in maintenance, they are the only factors used. No evidence was provided to support HEW's opinion.

HEW said that the factors considered in the determination of maintenance tend to be common to all urban rat control programs, however, the significance of the other factors varies markedly from project to project. Also, HEW stated that project managers are required to define objectives and implement operations designed to ameliorate conditions conducive to rat infestation which exist in their individual target areas.

Other problems impeding progress

Sanitation codes

When streets, alleys, and vacant lots become littered with refuse and there is a general neglect of buildings and neighborhoods, rats find the food and harborage necessary for existence. Promoting, developing, and enforcing adequate santitation codes to control these conditions are essential for an effective rat control program. However, some projects have been unable to accomplish this.

Rat control projects responding to our questionnaire identified the problems in the table below as affecting local santitation codes.

Problem areas	Extent of problem Minor	Moderate	Substantial	Serious	Total
Having adequate sanitation codes	10	6	1	-	17
Enforcement of sanitation codes	11	12	4	6	33
Insuring that violators are adequately penalized	10	12	8	4	34
Obtaining cooperation from and coordination with responsible agencies	12	7	3	1	23
Getting clear and proper authority to insure necessary action	11	6	2	4	23

Support by the residents

Urban rat control has been termed a "people problem" because it involves human behavior, lifestyles, and all the social and economic factors characterizing inner city life. By communicating with residents and motivating them to maintain a sanitary environment, rat control projects hope to minimize the conditions conducive to rat infestation. However, transient living conditions, public apathy, longstanding careless habits, and inadequate understanding of the importance of rat control have made community support a problem for most projects. For example, 35 of the 45 questionnaire respondents believed one of the obstacles confronting their program came from their attempts to deal with uncooperative residents and proprietors.

One project director said educating target area residents has been one of the project's biggest problems because it has had to (1) motivate residents to alter past habits, (2) try to win the residents' confidence by overcoming language barriers posed by the Spanish-speaking community, and (3) cope with transient populations through continuing education.

Another project director stated the large transient population in his city has created apathy among these temporary residents which can only be overcome through intensive health education efforts.

CONCLUSIONS

Controlling the conditions conducive to rat infestation, not exterminating individual rats, is the key to a sucessful rat control program. In doing this, major emphasis must be placed on improving the physical and social environment through (1) attaining community support, (2) implementing effective environmental sanitation programs, and (3) eliminating food, water, and harborage sources. The inability of rat control projects to adequately deal with these situations has slowed the program's progress.

Funding deficiencies have also hindered the program's effectiveness. The following comments by rat control project officials emphasize the seriousness of this problem.

--The current downward trend in funding will severely hamper maintenance efforts and negate the progress achieved during the first 5 years of funding.

--Continued funding cutbacks are unrealistic in view of (1) continuing efforts required to control rats and the conditions in which they thrive and (2) recent inflationary trends.

--Long-term improvement and overall program success require time and effort and depend on funds available. Considering current funding trends, there is doubt whether accomplishments can be maintained.

--Present funding trends will eventually eliminate rat control programs or affect them to the point that inner city conditions will deteriorate and rat populations will increase to base year levels.

Although we do not dispute the logic on which HEW funding policy is based, absolute adherence to such a policy without assurance that alternative funding is being generated by non-Federal sources has created problems.

Also, the constraints which determine maintenance understate the true extent of actual or potential rat problems. To present a more realistic portrait of project progress and to provide HEW and the Congress with a better basis for evaluating accomplishments and making decisions regarding the program's direction, we believe the criteria for determining maintenance should be expanded to include all conditions conducive to rat infestation.

The national war on rats, which began in late 1968, has had some success despite extreme difficulties. However, the remaining problems are of sufficient significance to jeopardize the program's future.

RECOMMENDATIONS

We recommend that the Secretary, HEW, require the Director, CDC, to reassess CDC's role in funding urban rat control programs. The Director needs to improve implementation of the "seed" money concept to make it more effective in promoting and maintaining urban rat control programs. Specifically, he should make the annual award of Federal funds conditional on the grantee's firm commitment of financial support. Such a practice will require that CDC and the grantee develop information on the total funding needed for an effective program and agree on the amounts to be furnished by each party. Without such an agreement, Federal funds should be denied.

We further recommend that, to improve program performance and to adequately measure accomplishments, the Secretary require the Director to

--revise the criteria for establishing maintenance in target areas so that reported accomplishments accurately reflect environmental conditions within the community and

--help rat control projects to
(1) strengthen and enforce sanitation codes and
(2) obtain optimum community support.

AGENCY COMMENTS AND OUR EVALUATION

HEW informed us that it supports the concept that Federal grants be used to develop rat control programs which in the long run should be sustained by State and local governments and has vigorously encouraged grantees to increase local funding. To continue implementing this concept HEW said that CDC and the regional offices will

--implement a phased reduction in Federal support of individual projects unless special situations exist,

--work with States and grantees to help identify additional non-Federal sources of funds, and

--monitor projects to assure that the level of effort is maintained as the level of Federal funds is reduced.

In addition to the above actions, we encourage HEW to make the grantee's firm commitment on a specific level of local financial support a condition of the annual Federal grant award. If the grantee will not make such a commitment or has not met its previous year's commitment, then Federal funds should be denied.

HEW informed us that national criteria are essential to provide a set of standards for evaluating the extent to which project areas have achieved maintenance and that such standards should address conditions which are both severe and common to all urban rat control programs. Although HEW considers the factors in the current criteria to be the most appropriate indicators of maintenance for the great majority of project areas, HEW agreed that circumstances in some areas require consideration of interior infestation in determining maintenance. HEW stated that interior infestation will be incorporated in the maintenance criteria in those areas where it is a major problem. However, HEW recognized that a variety of other conditions conducive to rat infestation must be addressed by the local program managers in addition to those reflected in national standards.

In addition to the above revision, we encourage HEW to revise its maintenance criteria to include some other conditions conducive to rat infestation so that progress reported to HEW accurately reflects environmental conditions within the community. We found only one of the six projects we reviewed had made any adjustment to HEW's maintenance criteria; however, they all exhibited most of the other conditions conductive to rat infestation (see p. 17) and officials of those projects thought that the maintenance criteria should be revised. Of the 45 respondents to our questionnaire, 44 believe that maintenance criteria should be changed. (See p. 20.)

Also, HEW said that CDC will provide technical assistance to States and to local grantees to improve the implementation and enforcement of effective codes. CDC will also help grantees develop techniques designated to enhance the participation and support of community residents in achieving rat control objectives.

CHAPTER 3

SCOPE OF REVIEW

Our review was conducted at CDC in Atlanta, Georgia; HEW regional offices in Philadelphia, Pennsylvania (region III), and Atlanta (region IV); and six rat control projects located in cities in Pennsylvania, Maryland, Virginia, Georgia, and Tennessee.

The six projects reviewed were responsible for about 22 percent of the city blocks in Federal rat control target areas as of December 31, 1973, and had received almost 21 percent of the Federal grant funds during fiscal year 1974. These projects had reported 64 percent of their blocks to be in maintenance at December 31, 1973, as compared to the 34 percent average for the other 41 projects active at that time. (See app. III for description of the six projects.)

We reviewed documents, reports, and files, and interviewed agency and project officials. In addition, we accompanied HEW representatives on inspections of 180 rat control maintenance blocks. At each project location, we selected a random sample of 30 blocks from the list of blocks in maintenance. We also sent questionnaires to all 47 rat control projects operating with fiscal year 1973 Federal grant funds; replies were received from 45.

RAT CONTROL GRANTEES AND PROJECTS
RECEIVING FEDERAL FUNDS AS OF JUNE 30, 1974

HEW region	Grantee	Project	Year of project	FY 1974 Federal grant	June 30, 1974, target area status		
					Blocks in target area	Blocks in mainte-nance	Percent of mainte-nance
				(In thousands)			
1	Worcester, Mass.	Worcester	4	$ 79.3	853	78	9.1
2	New York State (note b)	New York	6	2,252.1	1,761	545	30.9
		Buffalo	6		2,536	2,190	86.4
		Syracuse	5		326	262	80.4
		Rochester	6		469	238	50.7
		Cohoes	3		115	55	47.8
	New Jersey State (note b)	Trenton	6	1,033.1	225	-	-
		Camden	5		63	-	-
		Jersey City	5		235	50	21.3
		Newark	6		413	98	23.7
		Patterson	5		149	72	48.3
		Plainfield	5		157	18	11.5
		Hoboken	6		200	74	37.0
	Puerto Rico (note b)	San Juan	3	287.9	571	373	65.3
		Mayaguez	a/3		240	171	71.3
3	Philadelphia, Pa.	Philadelphia	6	1,716.4	3,453	2,471	71.6
	Allegheny County, Pa.	Pittsburgh	6	457.1	1,475	958	64.9
	York, Pa.	York	3	32.0	681	511	75.0
	Chester, Pa.	Chester	2	67.0	530	-	-
	Northeastern Pa. Vector Control Association	(6 communities in Scranton - Wilkes-Barre area)	2	237.0	587	127	21.6
	Baltimore, Md.	Baltimore	6	448.1	2,078	1,235	59.4
	Washington, D.C.	Washington, D.C.	6	630.4	1,261	1,082	85.8
	Youth Pride, Inc.	Washington, D.C.	6	88.5	206	90	43.7
	Norfolk, Va.	Norfolk	6	62.8	1,416	1,169	82.6
4	Economic Opportunity Atlanta, Inc.	Atlanta	6	165.0	504	318	63.1
	Nashville, Tenn.	Nashville	6	232.3	1,894	1,202	63.5
	Memphis-Shelby County, Tenn.	Memphis	3	305.6	1,824	112	6.1
	Mecklenburg County, N.C.	Charlotte	6	30.4	529	209	39.5
	Louisville and Jefferson County, Ky.	Louisville	1	205.0	1,327	-	-
	Mobile County, Ala.	Mobile	1	171.0	265	-	-
5	Chicago, Ill.	Chicago	6	940.0	2,581	756	29.3
	Cleveland, Ohio	Cleveland	6	238.7	1,307	408	31.2
	Akron, Ohio	Akron	1	120.0	229	-	-
	Detroit, Mich.	Detroit	1	175.0	738	-	-
	Flint-Genesee County, Mich.	Flint	3	160.0	1,091	812	74.4
	Health and Hospital Corporation of Marion County, Ind.	Indianapolis	3	160.0	382	-	-
	Fort Wayne-Allen County, Ind.	Fort Wayne	2	89.0	362	22	6.1
	Milwaukee, Wis.	Milwaukee	6	350.0	1,174	344	29.3
	St. Louis County, Minn.	Duluth	1	105.0	241	-	-
6	New Orleans, La.	New Orleans	4	271.2	2,882	1,403	50.1
	Tulsa City-County, Okla.	Tulsa	2	85.0	602	526	87.4
	New Mexico State	(3 communities in State)	2	129.5	1,372	-	-
	Arkansas State	(2 communities in State)	2	100.7	219	-	-
	Houston, Tex.	Houston	3	206.5	755	404	53.5
7	St. Louis, Mo.	St. Louis	6	273.5	1,530	955	62.4
	Kansas City, Mo.	Kansas City	2	109.2	709	-	-
	Kansas City, Wyandotte County, Kan.	Kansas City	3	119.7	981	86	8.8
9	City and County of San Francisco, Calif.	San Francisco	2	67.1	220	55	25.0
	San Mateo County, Calif.	East Palo Alto	4	152.0	174	89	51.1
	Contra Costa County, Calif.	Richmond	3	166.5	430	216	50.2
	California State	East Oakland	1	210.0	158	-	-
10	Seattle-King County, Wash.	Seattle	2	191.9	793	774	97.6
	Total			$12,921.5	45,193	20,558	45.5

a/Considered a new project in FY 1974 although actually in operation with a Puerto Rico grant since FY 1972.

b/Funds provided in State grants cover all projects in the State.

RAT CONTROL GRANTEES AND PROJECTS

NO LONGER RECEIVING FEDERAL FUNDS

HEW region	Grantee	Project	FY terminated
2	East Harlem, N.Y.	East Harlem	1972
2	(a)	Binghamton	1973
2	(a)	Poughkeepsie	1973
2	(b)	East Orange	1974
9	Bay Area Health Association, Calif.	(c)	1974

a/Terminated by New York State grantee.

b/Terminated by New Jersey State grantee.

c/Grantee's two projects--San Mateo County and Contra Costa County--became separate grantees.

DESCRIPTION OF RAT CONTROL PROJECTS REVIEWED

Atlanta, Ga.

As a sixth year project on January 1, 1974, Economic Opportunity Atlanta, Inc., is one of the three private organizations funded by HEW. As such, the organization must depend extensively on its relationship with the local government to provide supplemental sanitation and enforcement services for the project. The project services about 59,000 residents in its 6-1/2-square-mile target area with a staff of about 21 employees. In terms of Federal funding, Atlanta can probably be considered a medium-size project.

As of June 30, 1974, 318 (63 percent) of the 504 target area blocks had been put into maintenance and operations had not yet begun in 81 other blocks.

Baltimore, Md.

As a component of the Baltimore City Health Department, the Rat Eradication Program went into its sixth year of Federal funding on December 1, 1973. Baltimore, a large federally funded project, employs about 50 employees to service the 345,000 residents in its 19-square-mile Federal target area. A separate unit within the health department provides services outside the target area. Other city departments provide basic sanitation services in the target area.

As of June 30, 1974, 1,235 of 2,078 target area blocks (59 percent) had been put into maintenance and operations had not yet started in 500 other blocks.

Nashville, Tenn.

On January 1, 1974, Nashville went into its sixth year of Federal rat control funding. Under the direction of the Nashville Metropolitan Health Department, the project serves 116,000 residents in its 30-square-mile target area. The project is medium sized with respect to Federal funding. About 20 employees provide basic rat control services. Other city departments provide basic sanitation services.

On June 30, 1974, 1,202 (63 percent) of 1,894 target area blocks were under maintenance although all blocks had been worked.

Norfolk, Va.

On April 1, 1974, Norfolk entered its sixth year of rat control operations with Federal funds. As part of the Norfolk City Health Department, the project services approximately 97,000 residents in its 12-square-mile Federal target area. About 15 employees provide rat control services and the city's sanitation department provides basic sanitation services. Services outside the Federal target area are provided on a complaint basis. In terms of funding, Norfolk is one of the smaller rat control projects.

As of June 30, 1974, Norfolk reported that 1,169 (83 percent) of its 1,416 target area blocks were in maintenance, with the remaining blocks being under attack phase operations.

Philadelphia, Pa.

Philadelphia went into its sixth year of Federal funding on February 1, 1974. Operating under the direction of the Department of Public Health, and in cooperation with four other city departments, this has been the most heavily funded Federal rat control project and is the largest in terms of target area blocks. The Philadelphia project serves over 500,000 persons in its 13.1-square-mile inner city target area with a staff of about 250 full-time employees. The project also conducts less intensive complaint oriented rat control operations outside the target area.

As of June 30, 1974, Philadelphia had reported 2,471 (72 percent) of its 3,453 blocks under maintenance although all blocks had been worked.

York, Pa.

In its third year of funding on July 1, 1974, York is one of the smaller projects in terms of Federal funding. As a component of the City of York Department of Community Development, the project serves over 50,000 residents in a 5.3-square-mile area. Approximately nine employees provide rat control services. The city provides basic sanitation services.

On June 30, 1974, all of York's 681 blocks had been put under attack phase operations and 511, or 75 percent, had been put into a maintenance status.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUL 14 1975

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report to the Congress entitled, "The Urban Rat Control Program is in Trouble." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John Young

John D. Young
Assistant Secretary, Comptroller

Enclosure

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COMMENTS ON GAO DRAFT REPORT TO THE CONGRESS ENTITLED, "THE URBAN RAT CONTROL PROGRAM IS IN TROUBLE"

GAO RECOMMENDATION

"The Secretary of HEW should require the Director, Center for Disease Control, to reassess the Center's role in funding urban rat control programs. To improve implementation of the 'seed' money concept, the Director should make the annual award of Federal funds conditional on a firm commitment of financial support from the grantee. Such a practice will require that CDC and the grantee develop information on the total amount of resources needed for an effective program and agree on the amounts to be furnished by each party. Without such an agreement, Federal funds should be denied."

DEPARTMENT COMMENT

We fully support the concept that Federal grants should be used to develop rat control programs which in the long run should be sustained by State and local Governments, and have vigorously encouraged grantees to increase local contributions. The federally funded portion of projects has decreased from 73 percent in 1969 to an estimated 41 percent in 1975.

To continue this, CDC and the regional offices will (1) implement a phased reduction in the Federal support of individual projects unless special situations exist; (2) work with States and grantees to assist in identifying additional non-Federal sources of funds; and (3) monitor projects to assure that the level of effort is maintained as the level of Federal funds is reduced.

GAO RECOMMENDATION

"The Secretary should also require the Director to revise the criteria for establishing maintenance in target areas so that accomplishments reported by the rat control projects show the true extent of environmental conditions existing within the community."

DEPARTMENT COMMENT

National criteria are essential to provide a set of standards on which to base a determination of the extent to which project areas have achieved maintenance. These standards should address conditions conducive to rat infestation which are both severe and common to all urban rat control programs.

Although we consider the factors included in the current criteria to be the most appropriate indicators of maintenance for the great majority of project areas, we agree that circumstances in some local areas require the consideration of interior infestation in determining the extent to which maintenance is achieved. For those areas where interior infestation constitutes a significant problem, it will be incorporated in the criteria for determination of maintenance. We recognize that a variety of other conditions conducive to rat infestation must be addressed by local program managers in addition to those reflected in national standards. These factors are covered in the guidelines and are discussed in the urban rat control survey manual.

GAO RECOMMENDATION

"The Secretary should also require the Director to assist rat control projects in developing ways to (1) strengthen and enforce sanitation codes, and (2) obtain optimum community support."

DEPARTMENT COMMENT

CDC will provide technical assistance to States and to local grantees to improve the implementation and enforcement of effective codes. CDC will also assist grantees in developing techniques designed to enhance the participation and support of community residents in achieving rat control objectives. One of the program elements is the hiring, training, and career development of local residents, with particular emphasis on target area residents. In addition, the program stresses the establishment of effective communication with the people living in target neighborhoods, winning their support and cooperation, motivating them to handle their refuse and garbage properly by storing it in approved containers and by performing their housekeeping in ways that will deprive rats of the food and harborage which they must have to live and multiply. The cooperation of municipal authorities will be vigorously sought to implement the regular removal of garbage and other debris.

TECHNICAL COMMENTS

In addition to the foregoing comments on the GAO recommendations, the Department offers the following for clarification.

GAO COMMENT

"Although rat control program guidelines state that "projects will be given a higher priority for funding when they show a strong prospect for continuation when Federal support terminates," HEW regional and CDC officials both advised us that non-Federal input is no greater or less a consideration than any other factor in making final award decisions.

"One HEW official advised us that grantees are made aware that local input is required as part of their grant obligation and he stated that grantees are continually encouraged to increase local contributions. However, we found no grant termination because of a failure to contribute non-Federal funds to the program although such a contingency is provided for in rat control program funding criteria."

DEPARTMENT COMMENT

Approximately 80 percent of rat control projects currently in operation have increased their non-Federal support since they were initially funded, although not by amounts equal to the decreases in Federal support. In view of the severity of the rat problem in project cities, such failure to offset completely the reductions in Federal funding has not received overriding consideration in decisions to institute or continue Federal grant funding.

GAO COMMENT

"CDC officials advised us that exterior rat signs, unapproved refuse storage, and exposed garbage are the only conditions considered in determining maintenance because HEW considers these to be the most important factors in establishing whether blocks are in maintenance. No other evidence was provided to support this position."

DEPARTMENT COMMENT

Those conditions considered in the determination of maintenance tend to be common to all urban rat control programs. The significance to other conditions, however, varies markedly from project to project. Therefore, project managers are required to define objectives and implement operations designed to ameliorate conditions conducive to rat infestation which exist in their individual target areas.

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY, HEW:		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
ASSISTANT SECRETARY FOR HEALTH:		
Theodore Cooper (acting)	Feb. 1975	Present
Charles C. Edwards	Apr. 1973	Feb. 1975
Richard L. Seggel (acting)	Jan. 1973	Apr. 1973
Merlin K. DuVal	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	July 1971
Philip R. Lee	Nov. 1965	Feb. 1969
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (note a):		
Harold O. Buzzell	May 1973	June 1973
David J. Sencer (acting)	Jan. 1973	May 1973
Vernon E. Wilson	May 1970	Dec. 1972
Joseph T. English	Jan. 1969	May 1970
Irving Lewis (acting)	Sept. 1968	Jan. 1969
Robert Q. Marston	Apr. 1968	Sept. 1968
DIRECTOR, CDC:		
David J. Sencer	Feb. 1966	Present

[a] Effective July 1, 1973, the Health Services and Mental Health Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. Most Health Services and Mental Health Administration functions were transferred to four new agencies: CDC; the Health Resources Administration; the Health Services Administration; and the Alcohol, Drug Abuse, and Mental Health Administration.

Mr. ROGERS. Thank you very much, Mr. Ahart, for a very thorough statement. The committee will be particularly interested in the recommendations you have made.

Mr. Preyer.

Mr. PREYER. Thank you, sir.

I do not have any questions on the rat control bill but perhaps you would be the proper officer for me to ask this question of.

I have long supported what the CDC has done. I recognize, as you pointed out, there are a number of problems, many of those in the area of immunization, and there have particularly been budgetary problems.

For that reason we are concerned that the purchasing practices make the best use of the funds that are available. I understand the CDC advertised for vaccine and that 2.1 million were single doses.

Are you familiar with this particular aspect, Mr. Ahart, or should I ask this question of someone else?

Mr. AHART. I do not have any direct knowledge of the situation you are talking about.

We did do some work in the CDC immunization program area about a year ago. We felt that there could be economies achieved with greater centralized purchasing of some of these things, with CDC furnishing the vaccines and other agents to the States. I do not have any personal knowledge of the advertised procurement that you are speaking of today.

Mr. PREYER. I will reserve those questions for later on.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Thank you.

I believe for the first time in a few years we have had cases of bubonic plague in the United States, right?

M. AHART. I think so. I think the statistics on that show 5 cases in 1969, 13 in 1970, 2 in 1971 and 1 and 2 respectively in 1972 and 1973.

Mr. CARTER. In New Mexico, as I understand it.

Mr. AHART. I think Mr. Farabaugh has some more recent information.

Mr. FARABAUGH. Sir, there has been some news releases about 6 months ago of reported cases in New Mexico.

Mr. CARTER. Yes.

Mr. FARBAUGH. I think there were three or four reported cases there near an Indian reservation.

Mr. CARTER. Did rats cause the disease?

Mr. FARABAUGH. Various rodents can carry the disease such as prairie dogs.

Mr. CARTER. That is quite true but the major carriers are considered the rat family. There are, three principal types of the rat family: ratus, the Norwegian brown rat, and the black rat; is that correct?

Mr. AHART. I think we will accept your authority.

Mr. CARTER. There may be another one or so. But that is quite true. Of course our "seed" money goes to the States. What were the requirements—that we give 85 percent of the money to begin with, and diminish it as we went on?

Mr. AHART. In the rat control program my understanding is that there was a requirement for some share of the cost but legislatively there has never been a specific requirement on the extent of matching.

HEW has adopted an administrative policy of reducing funding and phase out.

Mr. **Carter**. And the States have not made up this difference. The money provisions from HEW which I think are vital and necessary, have diminished. I feel we need cleanup programs all through our country to get rid of the places that harbor rats. Also our homes, as nearly as possible, should be rat proof. As you said in your statement, it is not necessarily extermination but control and elimination of sites where they can breed, as I see it.

I think you have made a good statement. I do believe that community interest should be increased and I think that is where one of our great difficulties is. The communities themselves have not become interested enough in these programs. Whether this is from poor leadership or what, I am not sure. I have seen some of the rat controllers, talked with them and those employed by the States, and find that they take many coffee breaks, and are not too interested. It seems, they travel a great deal but exterminate few rats or abate few circumstances which permit rats to live.

I regret this. I think we need a dynamic leadership and more effective assistance from the States. I regret that the communities themselves are not more interested.

I know when I was a youngster many cities in Kentucky and many little towns, put a bounty on rats. Of course this was the idea of extermination but if we do not get rid of the sites that harbor them, we do not get rid of the rats.

Mr. **Preyer** [presiding]. Mr. Florio.

Mr. **Florio**. Sir, to get some basics. I recall when we considered the health revenue-sharing bill, there was an appropriation authorized of $20 million for rodent control programs.

Where does that fit in with regard to what we are doing, is that a different program?

Mr. **Ahart**. I will ask Mr. Farabaugh to answer that.

Mr. **Farabaugh**. Sir, the authorizing legislation prior to the Health Revenue Sharing Act was contained in section 314 (e) of the Public Health Service Act. Rat control was not specifically cited as being included within that legislation but it was permitted for funding of the various project grantees. The Health Revenue Sharing Act included a provision to amend section 317(h) of the Public Health Service Act so as to include rodent infestation within the term of definition of disease control. It authorizes specifically rat control activities or rodent control activities within the Public Health Service Act. It would receive funding along with other types of communicable disease but $20 million was specifically cited for rodent control under section 602 of the Public Health Service Act.

Mr. **Florio**. How does this complement this bill? I assume that the programs are going to be coordinated, that is, the authorizing under that bill as well as the authorizing under this bill; is that a correct assumption?

Mr. **Farabaugh**. I think they are coordinated, sir. I think this bill also specifically provides for rodent infestation to be included within the disease control programs.

Mr. **Florio**. And the authorization for the disease control program is what in this bill?

Mr. Farabaugh. In H.R. 8278?

Mr. Florio. Yes.

Mr. Farabaugh. I am not sure of that, sir. I do not think it is specifically cited for rodents.

Mr. Florio. That is the point I am getting to. What we have is an authorization for disease control and we enumerate a number of elements. What I am trying to do is compare what the money is that has been allocated previous to this approach. For example, we are throwing lead poisoning in, and I am just trying to ascertain whether the total cumulative amount of money that is going to be authorized is equal to the individual categorical amounts for each of these programs. That is to say for each of these individual programs if you add them all up, they may be substantially less than the total cumulative amount.

I am trying to ascertain what those amounts are. Do you have any idea?

Mr. Farabaugh. I do not have the actual figures for all of the other types of disease control programs included within that so I do not have that total for you.

Mr. Florio. I think you said there were 19 grantees in the country; right?

Mr. Ahart. There were a total of 52 projects, Mr. Florio; 19 were ones that had gone to the 6th year of funding.

Mr. Florio. I see. Now, when you say projects, for example, the State of New Jersey, is that regarded as a recipient, because I know in fact there were two major projects, city of Newark and Camden—what is described as a project, the State receipt of the money or the individual locations where these programs are in operation.

Mr. Ahart. I would have to find the statistics on the New Jersey case I think Mr. Benchoff probably has the information readily available.

Mr. Benchoff. New Jersey is a grantee. New Jersey has six projects. The cities are the projects.

Mr. Florio. Is that six grants or is that one grant through the district office.

Mr. Benchoff. One grant.

Mr. Florio. Through the District Office of HEW?

Mr. Benchoff. Yes, to the State.

The State allocates the money within the State. This also happens in New York State.

Mr. Florio. I am very impressed with the Camden project and every year we go through a trauma as to whether it is going to be funded or not and it is always at last moment that we go up and we have to argue with people in the State and in turn they point to people in the district office, I believe the HEW District Office in New York, and I am wondering if there is any way that we can provide a greater certainty, because one of the criticisms I heard of these programs, there is no maintenance effort and you are not going to find the maintenance effort when the people are not sure that the funding is going to be continued.

Is there anything you can recommend that is going to provide for a higher degree of certainty in these programs? Perhaps we can shorten the procedure of going to the region, going to the State, and ultimately going to the district, with an awful lot of discretion being given to the State to the financing in each of the locations.

Is this the concept that was originally contemplated by HEW, that it would be left to the discretion of the State to fund individual projects and HEW should have nothing to say as to the merits of the particular project?

Mr. AHART. I think this is largely a question of how the State or locality chose to do business with the Federal Government. HEW has funded cities as grantees as well as States. So that in many of the projects the city has a direct relationship with HEW which would avoid the uncertainty of action at the State level that you are talking about; and, in other cases, such as New Jersey, you have the State being the grantee and the State in turn parceling out the money to the local projects.

Mr. FLORIO. Does the district office of HEW review the projects in the situation such as New Jersey with the State as the essential grantee?

Mr. BENCHOFF. They should be monitoring the total activities under the auspices of that grantee which requires they monitor what goes on at the project level.

Mr. FLORIO. The process of monitoring, is that anything more than just a passive monitoring, is there an attempt to become involved in the State decision as to, for example, in the city of Camden, and I think in the city of Newark as well, the project has been authorized, I think it is about an eight-square-block area in South Camden. To determine the degree of success of the program is very difficult because I understand the rats are relatively smart. If you take an eight-block area and you attempt to clean that up, it may well be the surrounding area is now much greater, has a much greater degree of infestation, which is probably the case.

I suppose we can really make the argument, and the point in a large context that in our area we are now finding the city of Camden is much more rat free, we are finding also that suburban areas have a difficult problem with regard to rats. You do not have to be a genius to figure out what is going on.

I am wondering if, in fact, we should be having a broader approach toward the problem rather than this hit-and-miss target area approach, that perhaps we should be attempting to coordinate activities on a broader level.

Is there anything like this being done with regard to the oversight functions of HEW on these projects particularly the projects where the money is filtered through some intermediate agencies such as the State?

Mr. AHART. Of course, the Federal program is one which is supposed to stimulate the local efforts and get the Federal Government out of the business eventually.

Mr. Benchoff, who has been around quite a number of these projects and is very familiar with how it operates at the local level and the relationship with the State and HEW could probably respond more specifically to your question.

Mr. BENCHOFF. Yes; HEW does monitor the projects, but HEW leaves it to the States to decide what cities and how much the cities will get. HEW determines how the State will get a grant, what the grant will be and then the State filters it out to the cities. HEW does have the right of approval over the number of blocks in the target area selection, but——

Mr. Florio. I am sorry.

Mr. Benchoff. HEW has the right of approval over the selection of blocks in the target area but it is mostly perfunctory; HEW approves those automatically.

Camden is 63 blocks rather than 8, which is fairly small.

Mr. Florio. Yes. I will just conclude on this point. We are running into a real basic philosophic question that has to be resolved. We say the Federal Government is to be the innovator. We are giving the seed money to get the thing started. All we have to do is pick up the newspaper to look at the New York situation. There are many instances where we are finding these programs are the cause of many of the problems of your cities and States. It is nice to throw out the bait and have a city or a State initiate the program.

But we have one or two approaches as the State or city revenues fall off; they are not able to come up with the appropriate money. They do one of two things. They use the money to the detriment of other services or else the program starts to fall off and in 5 or 6 years we find we have almost wasted the money, particularly in a situation like this. We have wasted the Federal involvement because the effort has not been sustained. What I am suggesting is we are going to have to rethink the whole concept of the seed money. It may well be decided it is silly and foolish because the States and cities cannot sustain the burden imposed upon them by the increasing contribution concept and either we go at it wholesale and say the Federal Government has responsibilities to stay in the area and perhaps do it and address the program on a comprehensive basis, or else we are just wasting time and money.

So I think we are going to have to resolve this thought because I really do not see anything being done, notwithstanding your statistics, it is impressive, we have less bites from rats but the fact is if you are diffusing the problem out into other areas, I think this is clearly the case, and we are not going to have a continuing, ongoing monitoring system which does not turn to entities with cities, States, and counties, that are not going to be able to continue the effort and there is some question being raised as to the desirability initial effort in the first place because there is nothing worse in my opinion than holding out high expectations to individuals and then leaving them hang at the other end, so I think, hopefully this committee will get into the basic philosophy behind programs such as this and if, in fact, there are some major modifications that have to be made, I hope we will be making them.

Thank you, Mr. Chairman.

Mr. Preyer. Thank you very much, Mr. Ahart, we appreciate your recommendations and your testimony here.

Let me just ask, in conclusion, do you have any recommendations that we write anything into the law; is there something we should change in the law that would help invigorate these programs?

Mr. Ahart. I think probably the recommendation we made to HEW is one that could be considered legislatively. As the program now stands, it is pretty much up to HEW what kind of matching requirements would be required of the State and local communities, and also what kind of commitment for future funding is to be made.

The thought we had on the basis of our review is that it does not make too much sense to us to take the Federal initiative and spend the funds in places where you do not have assurance of a local commitment to carry through once Federal "seed" money has been exhausted.

I do not have any thoughts on whether it is better to do it legislatively or administratively, but it is certainly something that could be handled either—through either vehicle.

Mr. PREYER. Thank you. We appreciate your testimony.

Our next witnesses are from HEW. I understand that Dr. Dickson will not be able to be with us today and that his testimony will be given by Mr. Dale W. Sopper.

Mr. SOPPER. Yes; that is correct.

Mr. PREYER. Perhaps if you would introduce your associates.

STATEMENT OF HON. JAMES F. DICKSON III, M.D., ACTING DEPUTY ASSISTANT SECRETARY FOR HEALTH, PRESENTED BY DALE W. SOPPER, ACTING DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY J. DONALD MILLAR, M.D., DIRECTOR, BUREAU OF STATE SERVICES, CENTER FOR DISEASE CONTROL; VERNON N. HOUK, M.D., DIRECTOR, ENVIRONMENTAL HEALTH SERVICES DIVISION, CENTER FOR DISEASE CONTROL; JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL; AND MILTON PUZISS, M.D., CHIEF, BACTERIAL AND MYCOTIC DISEASE BRANCH, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH

Mr. SOPPER. If I may, I would like to introduce the individuals who are accompanying me. On my left is Dr. J. Donald Millar, who is Director of the Bureau of State Services of the Center for Disease Control of HEW. On Dr. Millar's left is James D. Bloom, who is Executive Officer of the Center for Disease Control. On my right is Dr. Vernon Houk who is Director of the Environmental Health Services Division of the Bureau of State Services for the Center of Disease Control. We also have with us Dr. Milton Puziss, who is the Chief of the Bacterial and Mycotic Diseases Branch, National Institute of Allergy and Infectious Diseases, NIH.

Mr. Chairman and members of the subcommittee, I am pleased to have this opportunity to discuss H.R. 7050, the control program amendments of 1975, and other bills. We have comments on those provisions of H.R. 8278, the National Health Education and Disease Prevention Act of 1975, and S. 1466, passed by the Senate July 30, 1975, which would extend authority for disease prevention and control programs, and revise and extend the authority for venereal disease programs. We will also comment on H.R. 4444, which would extend authorizations of appropriations for the Lead-Based Paint Poisoning Prevention Act.

To summarize our position, the Department supports enactment of the administration bill, H.R. 7050, and strongly opposes enactment of

H.R. 8278, S. 1466, and H.R. 4444. We believe H.R. 7050 represents a long overdue consolidation of disease control grant authorities, the elimination of inappropriate or duplicative grant authorities, and a level of Federal investment to accomplish program objectives.

DISEASE PREVENTION AND CONTROL

I shall first address comments to provisions of H.R. 8278 concerned with venereal disease and other prevention and control programs. I shall also discuss several key issues in S. 1466. Similar provisions to H.R. 6840, which was introduced by Mr. Rodino, are contained in title II of S. 1466. In addition, I shall comment on H.R. 7050, which was introduced by Mr. Staggers on behalf of the administration. H.R. 7050 combines disease control grant programs which are presently authorized by sections 317 and 318 of the Public Health Service Act, into a single authority, and adds to that authority existing grant programs directed toward rat control and lead-based paint poisoning.

H.R. 8278, the National Health Education and Disease Prevention Act of 1975, would revise and extend the existing authority for disease prevention and control programs; add rat control, lead poisoning, and several specific diseases to that authority; and revise and extend existing separate authority for the control and prevention of venereal diseases.

The bill would repeal the formula grant authority for diagnosis and treatment of venereal disease under section 318, which has never been used, but would add to section 317 a new grant and contract authority for training, demonstrations, and evaluation of the administration and operation of disease prevention and control programs.

S. 1466 contains authority for a variety of health programs including separate authorities for disease control programs and for venereal disease control as well as the provisions on health education and dental health activities. Title I of this bill would broaden the scope of the present section 317 by eliminating "communicable" each time it appears, and would add authority for grants for control of other "conditions."

Title II would amend section 318 of the Public Health Service Act to extend the authorizations for venereal disease control. The bill includes project grants for research, demonstration, and training; formula grants for diagnostic and training services; and project grants for control programs. The definition of venereal disease is broadened to include sexually transmitted diseases other than syphilis and gonorrhea.

ADMINISTRATION BILL

H.R. 7050 would provide one authorization for all the control program grants funded under sections 317 and 318 of the PHS Act, rat control project grants funded under section 314(e) of the act, and lead-based paint poisoning grants funded under title I of the Lead-Based Poisoning Prevention Act. The funding authorization for these programs would be consistent with the President's budget request for fiscal year 1976, which totals $34 million and is broken down as follows:

Venereal disease, $20 million; immunization, $5 million; rat control, $5.5 million; and lead-based paint poisoning, $3.5 million.

These funding levels would allow continued progress in these programs and accomplishment of program objectives.

We believe that the time has come to reverse the trend of project grant program authority proliferation and to combine grant authorities which have similar objectives and methods of administration. The Federal role in these programs should continue to be one of building State and local capacities to carry out disease control and environmental programs. Separate categorical authorities represent a fragmented Federal approach to these problems, which encourages rather than alleviates fragmentation at the State and local level.

Moreover, there should be increased reliance on the discretion and capabilities of State and local governments, and the private sector which requires a more limited Federal role. It is the Department's conviction that not every health program initiated by the Federal Government needs to remain a financial responsibility of the Federal Government indefinitely. As grantees increase their financial participation, they will have a greater incentive to review project management and possible efficiencies of operation, as well as project needs in light of internal sources of funding and other forms of Federal assistance. We will assist grantees in every way we can to identify other sources from which contributions can be obtained.

An example of the type of activity we envision is that currently going on during Immunization Action Month (IAM). The overall objective of IAM is to increase public awareness of the need to maintain immunity levels in populations at greatest risk, particularly preschool children. A steering committee, chaired by CDC, was established in 1973 at the national level composed of representatives of participating organizations. The responsibility of this committee has been to establish national goals, develop and update strategy, evaluate progress, develop and distribute materials—prototypes and finished products—develop resources and manage the implementation of the strategy. Similar committees were recommended and formed on a State-by-State basis under the leadership of State health agencies.

State and local health agencies have undertaken active educational-motivational activities through State and local mass media facilities. Special emphasis has been placed on working with organizations within the States that relate to the parents of young children. In total, over 70 national organizations are participating in the program.

Schools provide only one of the many communication vehicles in the overall IAM strategy. We do not know how many schools actually carried out an active immunization awareness program. We do know that many national educational organizations and their State and local chapters have carried out specific activities to promote IAM.

For example, the National Congress of Parents & Teachers was one of the organizations active in carrying out IAM at the national level and distributed information packets to each State chapter to stimulate school-based awareness programs aimed at school-age children and their siblings at home. Surveys of entering elementary school students have shown a slight increase in immunity levels.

In addition to providing for control program project grants, H.R. 6840, H.R. 8278 and S. 1466 would continue a separate grant authority for venereal disease research, demonstrations and training. We believe that there is adequate authority elsewhere in the Public Health Service

Act to carry out these functions. Similarly H.R. 6840 and S. 1466 would continue the venereal disease formula grant program, and expand its purpose, for upgrading diagnostic and treatment facilities. This program has never been funded, and we do not recommend that it should be. Inadequacies in venereal disease patient care should be addressed as part of the broad issue of quality medical care and not through categorical formula grant funding. Moreover, the flexible authority in the administration's bill will permit us to identify any gaps in venereal disease patient care if they develop.

The Department also objects to the provisions of S. 1466 which would add "conditions" to those purposes for which grants could be awarded. This language would require a virtually limitless expansion of our program objectives, well beyond the bounds of strictly health matters. Such authority would be highly inappropriate and would confuse and complicate the proper mission and responsibilities of the Center for Disease Control, the Public Health Service and the Department.

LEAD BASED PAINT POISONING PREVENTION

H.R. 4444 would amend the existing Lead-Based Paint Poisoning Prevention Act by extending the authorizations in section 503 through fiscal year 1977. The Department opposes the continuation of the separate categorical grant authority in H.R. 4444 and favors instead the broader and more flexible authority in H.R. 7050. The establishment of multiple categorical authorities causes considerable hardship on State and local health agencies trying to carry out well balanced, effective prevention programs and continues to make Federal assistance unnecessarily complicated.

SUMMARY

In summary, we support H.R. 7050 and oppose H.R. 3278, S. 1466, and H.R. 4444. H.R. 7050 would provide all necessary and appropriate Federal authorities in the area of disease control, and we hope it will receive favorable consideration by this committee.

That concludes my testimony. I shall be pleased to respond to any questions you or other members of the subcommittee may have. Mr. Chairman.

Mr. PREYER. Thank you, sir.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I believe, according to your testimony, that you oppose the treatment for venereal disease by health departments, is that correct?

Mr. SOPPER. We oppose using Federal funds to pay for it.

Mr. CARTER. They have been used over the years, Mr. Sopper.

Mr. SOPPER. I will let Dr. Millar discuss the Federal Government's support in the area of venereal disease.

Mr. CARTER. I shall be glad to have the gentleman's answer.

Dr. MILLAR. Thank you, Mr. Chairman.

I represent Dr. David J. Sencer today who is in China as a participant on a United Nations team. He is the U.S. representative there exploring environmental health problems.

As to venereal disease control, we have felt over the years that the primary Federal role should be one of supporting epidemiological investigations of the disease and interruption of its transmission by applying preventive medicine techniques. We have felt that the appropriate——

Mr. **Carter.** Mr. Chairman, I would like to ask what is the way you prevent transmission of syphilis?

Dr. **Millar.** Beginning with the patient who is infected, sir, an interview is conducted of that person to determine those persons, called contacts, from whom he may have acquired his disease and also those persons, also contacts, to whom he may have spread it.

Mr. **Carter.** We call that epidemiology, I believe.

Dr. **Millar.** Yes, sir.

Mr. **Carter.** Finding out the contact. What are we going to do with them when we find them?

Dr. **Millar.** We have those people treated when they are identified.

Mr. **Carter.** You do?

Dr. **Millar.** Yes, sir.

Mr. **Carter.** But yet you do not include funds here for that. You say you do not support Federal funding for such operations.

Dr. **Millar.** The States have been supporting the diagnostic and treatment aspects of venereal disease control for years.

Mr. **Carter.** The States have done this with Federal funds in many cases. I am sure they have been supporting them in the past. They may not at the present time. Of course epidemiologically as the usual thing is worked out by the health officer and sometimes by the physician. Most of the times the physician does not have the time and he is the man who elicits from the person who has the venereal disease his contacts and traces further from them. Sometimes it is very interesting, as you well know, to find the contact of one person and trace and find all of them but of course without the power to treat those people or without the funds to treat them, we have simply found a good story and that is about what it amounts to. We found the problem, but we have not solved it.

Somewhere along the way the health services throughout our Nation, particularly our public health and our preventive medicine services, have gone down the drain.

What percentage of our youngsters now are immunized in our schools?

Dr. **Millar.** Sir, it depends on the condition against which we are immunizing.

Mr. **Carter.** I know, but we have a general rate of immunization, a percentage of immunization through our country. Isn't it in the area of 40 percent?

Mr. **Sopper.** I think we can give you specifics.

Mr. **Carter.** If we put all the statistics together for immunization rates, can we take an average?

Dr. **Millar.** At the present time among preschoolers, sir, that is, ages 1 to 4, those with the history of vaccination against measles is 64 percent, those with a history of vaccination against rubella, 59 percent.

Mr. **Carter.** That is throughout the country?

Dr. Millar. Yes, sir. These are national figures. And against diphtheria, pertussis, and tetanus (DPT), 53 percent, and poliomyelitis, 63.1 percent. That is among preschoolers.

Mr. Carter. That is a little higher than I thought it was, but still we are letting a lot of youngsters go unprotected.

Is it a common practice in the hospitals in our country to give DTP on the birth of a child or soon after the birth of the child?

Dr. Millar. I do not have data on that, but in my opinion, that is not common practice.

Mr. Carter. It is common practice in some areas and I think it is a good practice that it be done. They should be immunized immediately against diphtheria, pertussis, and tetanus. As you may know, we have had an outbreak just this past year in the State of Maryland which was quite widespread, I guess. You are with the Communicable Diseases Center, I take it; is that correct?

Dr. Millar. Yes, sir.

Mr. Carter. You should be quite familiar with it. Am I right in my assessment of what has happened in the past year?

Dr. Millar. You are speaking of measles, sir.

Mr. Carter. Pertussis, whooping cough.

Dr. Millar. Yes; I am familiar with the fact that there has been a pertussis epidemic. I do not have intimate knowledge of that.

Mr. Carter. We are just falling down in these lines. We are not immunizing our youngsters. At one time every school child practically was immunized. Of course, the need for vaccination perhaps has gone down since we have almost eliminated smallpox. But, we have not eliminated it in Bangladesh and some African countries, the names of which escape me at the time.

Mr. Sopper. I would like to point out that the problem is primarily one of pockets of unimmunized people. Of course the preschoolers, the ones that concern us most, have the lowest immunization levels. Among school children, immunization levels are significantly higher but again, we have the continuing difficulty that among lower socio-economic groups especially, immunization levels are quite low. It is a matter of trying to reach these pockets of unimmunized people that has given us difficulty for many years.

Mr. Carter. How can these pockets be universally reached? We have a requirement in practically every State in the Union that every child who goes to the school be immunized. They can be reached right there as they enter school or before they enter; is that not true?

Mr. Sopper. Yes; it is true that essentially every State has a school entry law requiring immunization and, indeed, many of the immunizations are given at school entry. Unfortunately, many of these diseases have their greatest incidence in the years before school entry, so it is sometimes too late.

Mr. Carter. Yes; but if you followed the method I told you about, immunization with DTP particularly when a child is a week old, you would eliminate part of those; would you not? And, if we have an active public health organization throughout this country, we could eliminate these things. We do not have this kind of public health activity any more, it has become decadent in the past few years, I am afraid.

These children should be brought into clinics and immunized, particularly the poor children. Those who can afford it can go to their private physicians.

But this is something that we must take action on, as I see it and it may cost a little money but it will pay off in health in the future. This is something with which I am quite familiar and I have been involved in and I know whereof I speak. Our public health service and our States have gone down and you know it, too. We ought to do something about it.

Thank you, Mr. Chairman.

Mr. **Preyer.** Mr. Florio.

Mr. **Florio.** First of all, I commend Dr. Carter for a statement that certainly I agree with. I feel very strongly that certainly is an appropriate approach we should be taking with regard to the health care delivery system as it pertains to immunization, not only does it yield in my opinion, good health benefits, but I suspect you could probably, if you wanted to be purely mercenary and end up with a cost benefit as well, and I think we are starting to see this with regard to smallpox. We are on the verge of wiping out smallpox and the cost saving just from the requirement that we no longer immunize is a substantial cost saving. If you do not want to approach it from a health approach, if you want to cost it from a budgetary approach, you can ultimately invest enough money in this program to save money, and I would suggest he is 100 percent correct that we have to reach out to start providing some of these immunization programs.

Likewise, I see your program IAM that are you just going to have a giant health program, a volunteer thing, we are going to notify people and they are going to come in. The fact of the matter is it does not work in a lot of areas and, as a matter of fact, in those areas where the people are in most need—I speak with some degree of experience—you are in inner cities, you can put up all of the posters on the wall and notify people and send them out, but as a matter of fact, people are not going to really comply unless you are going to make it mandatory, and it is going to be a public health approach. So I would like to identify with Dr. Carter's remarks and urge that philosophy onto HEW.

I would like to get some basics.

Dr. **Millar.** Could I respond at this point.

I agree with you that a public relations campaign has not proven in the past satisfactory in reaching those people with whom you have the greater concern, that is, the inner city, especially, who are lower socio-economic people. There are Federal programs that address that specifically and I am thinking now of the early periodic screening, diagnosis and treatment program which is aimed at medicaid children who by and large fall into this group that we have just been talking about.

So there is active effort to try to reach this particular high risk group to get them immunized.

Mr. **Florio.** Probably the most unfortunate example you could have cited, it is my recollection that 11 or 12 or 13 States have just been cited by HEW for not complying with that. The money is not there, the outreach programs are grossly inefficient in the States because the funding has not been available.

Again the philosophy is there but the funding has just been accepted and the funding is not there, it has not been monitored, a number of States just in my understanding have been penalized because of their failure to abide by the terms of that program.

Am I correct in stating the program has not been successful?

Mr. **Sopper.** I think we disagree with you respecting the success of the program. There are approximately 13 million children who are eligible for EPSDT service. In the last fiscal year, we screened 1.5 million children which is the same amount that was screened in the previous 6 years of the program. So I think we feel we will have really made dramatic steps forward in moving the EPSDT program along.

Mr. **Florio.** I did not get your number. You say there were 13 million.

Mr. **Sopper.** About 13 million eligible.

Mr. **Florio.** 1 million were screened.

Mr. **Sopper.** 1.5 million screened just in the last fiscal year.

Mr. **Florio.** You regard that as a success rate?

Mr. **Sopper.** Well, when you consider that in the previous 6 years of the program a total of only 1.5 million had been screened, we think it is a dramatic step ahead in that we have been able to screen 1.5 million in just 1 year.

Mr. **Florio.** I am not going to make any comment, I could make sarcastic comments about the dramatic steps ahead.

Mr. **Sopper.** These children are not to be screened every year. The idea is that you do a certain number of screenings throughout the child and adolescent's life but you do not screen a child every year. You may screen him at 1 and again at 3, maybe when he is in grade school then again when he is an adolescent, but the State does not have to screen this pool of 13 million eligibles on an annual basis. There is no intent that the program works that way.

Mr. **Florio.** How many States was it that were cited by HEW?

Mr. **Sopper.** Ten States, I believe, that have been assessed penalties for failure to comply with the provisions of the statute.

Mr. **Florio.** I wish to ask a couple of questions as to your statement.

At one point when you say that there should be increased reliance on the discretionary capability of State and local governments and private sector which requires a more limited Federal role, how do you separate the private sector, what aspect of the private sector do you see coming in and picking up the functions of immunization?

I am talking about page 4, your bottom paragraph.

Dr. **Millar.** With respect to other sources or funding, I think perhaps IAM is one of the better examples of how private resources can be brought to bear on the problem of immunizable diseases. As we mentioned in the opening statement, there are some 70 organizations, many of which are voluntary private organizations, who are now at work in spreading the news that we must have higher levels of immunization in this country. In terms of what the States have been able to do in finding other sources of funding, we have already mentioned EPSDT. Also, there are HUD block grants for hazard abatement activities relating to lead based paint poisoning and rat control. The emergency employment programs which have recently been funded have provided some relief in the way of employees to work in disease control programs; MCH funds have also been used in lead screening and immunization activities.

So to this extent, the States have been able to find other funds to assist in disease control activities.

Mr. FLORIO. Could I ask what the status of the proposal is? There was a proposal earlier in the year, a former Secretary of HEW came in and advocated a reduction in the State's share of medicaid, or the Federal contribution of medicaid funds for a number of States. How was that proposal considered?

Mr. SOPPER. You are addressing the proposal to reduce the Federal matching from what is now a minimum of 50 percent down to 40 percent. To date no congressional action has occurred on that proposal.

Mr. FLORIO. Is that still the position of HEW?

Mr. SOPPER. That is still the administration's position.

Mr. FLORIO. Does not that seem somewhat inconsistent to say we should have increased State contributions when we are talking about early periodic screening tests being spanned and at the same time you are going to say we are going to cut back on Federal contributions and have the States pick up more of the share.

Mr. SOPPER. It is asking those States that are the high percent level to assume a greater share with respect to the medicaid program. That is correct. It is also not inconsistent in that we are saying for these activities the State should pick up an increased share.

Mr. FLORIO. I would like to get some specifics on the total amount, the same question I asked the previous speaker. We are talking about a $34 million authorization and you categorized the amounts that would be attributed to each of the areas. I am assuming this is not in the bill, this is not in any of these bills, what you are saying, the projection is of the $34 million, 10 would go for immunization, 5 for rat control, I am sorry, 20 for venereal disease, 5 million for immunization, 5.5 for rat control, lead-based poisoning 3.5. Those are the estimates.

Mr. SOPPER. Those are the figures from the present fiscal year 1976 budget.

Mr. FLORIO. But there will be no statutory authorization for that under these bills, that is to say the blanket amount would be 34 million, and then whatever HEW decides to do in allocating those funds will be what is done.

Mr. SOPPER. That would be handled in the annual appropriation process where the Department would propose to use the funds in certain categories.

Mr. FLORIO. So what I said is correct, it will be an administrative decision?

Mr. SOPPER. Except it will be ratified by the appropriations process and the Congress, that is, the Department will have to annually request the Congress for funds and will have to explain how it expects those funds to be used.

Mr. FLORIO. When they request the funds they will be requesting specific line items.

Mr. SOPPER. Not in the Appropriation Act, per se, but in the budget request that goes to the Congress, there will be a description of how the total is to be expended during the upcoming fiscal year.

Mr. Bloom, who testifies before the Appropriations Committees, may want to expound on this, but we just went through this process with the Appropriations Committee.

Mr. **Florio.** And the effect of that budget being submitted and being ratified by the Congress, are you telling me that that mandates that those moneys are to be spent in accordance with the provisions in the budget, that is to say, if it says $5 million for—$5.5 million for rat control in the budget and that is authorized and appropriated, that is not to say that HEW has to spend that amount, does it?

Mr. **Bloom.** Subject to any of the reprograming provisions within the appropriations, but before we could switch from one grant category to another, we would have to go through the reprograming process which, I believe, includes getting at least informal clearance from the congressional committee.

Mr. **Florio.** I do not understand the concept of informal clearance.

Mr. **Sopper.** If, for example, we testify to the Congress and the Congress approves a budget to do certain things, and in an appropriation, say, $25 million for a specific activity, and throughout the course of the fiscal year something happens which makes that $25 million perhaps excessive for those program needs, we would come back in a formal way through a letter to the chairmen and ranking minority members of the Appropriations Subcommittees, and request authority to reprogram those funds into another activity. The Appropriations Committee will either approve or disapprove that request.

Mr. **Florio.** You are not talking about rescissions and deferrals?

Mr. **Sopper.** No, sir.

Mr. **Florio.** Something less formal than that.

Mr. **Bloom.** Yes; that's why I was referring to it as informal rather than a formal process that goes through the hearings and so on.

Mr. **Sopper.** But the committees are consulted. The Secretary does not decide to arbitrarily transfer funds from one account to another. We cannot do that; we have to at least approach the Appropriations Subcommittees and get their permission.

Mr. **Florio.** You are talking about transferral. The same process works for failure to expend.

Mr. **Bloom.** That kind of action would fall under the new Budget Reform Act in terms of having to request either deferral or rescission. Under the provisions of that act as I recall it, sir, that is right.

Mr. **Florie.** The amount that we are talking about, $34 million, we categorize about four or five different programs.

If you have the figures, I would appreciate your telling me what is currently being spent for these five programs now. If we took the authorization for this year and added up those five programs, what would we come to as contrasted with $34 million?

Mr. **Sopper.** When you say "this year," I believe you are referring to fiscal year 1975 since we are now in 1976.

Mr. **Florio.** Yes.

Dr. **Millar.** Would you like the figures in categories?

Mr. **Florio.** If you do not mind, venereal disease.

Dr. **Millar.** $28 million.

Mr. **Florio.** That is an $8 million reduction.

Dr. **Millar.** Yes. Immunization, $6.2 million. Lead, $9 million. Rats, $13.1 million, for a total of $56.3 million.

Mr. **Florio.** So we go from $56.3 to $34. We are cutting each and every program by substantial amounts. The justification being that you do not feel that these programs are of value?

Mr. **Sopper.** No; we are saying these programs are valuable. What we are saying is that the States and localities should begin to assume a greater proportion of the cost of these programs.

Mr. **Florio.** I am not in any way being argumentative with you, but it just seems to me that anyone who reads the newspapers has got to realize that the States and localities are not in a position. My own State is ging through a big budget crisis like the city of New York. I cannot understand how someone can be so oblivious to what is going on in this country to say the States and municipalities are going to have to pick up more of the burden when we know very well they cannot.

Has anyone given any consideration to the fact of what is going to happen? Have we programed what is going to happen with the reduction of these things? It seems to me it is clear what is going to happen, the programs are going to be phased out. If we are willing to say they should be phased out, that is fine, I understand that. That does not say the programs are valuable and should be continued and we let someone pay for them who cannot pay for them.

Has anyone attempted to ascertain what is going to happen to these programs if they are reduced and the sponsors or grantees are not able to come up with the amount of money? Has anyone tried to get some commitment from someone whether they are going to be able to come up with these funds?

Mr. **Sopper.** I will let Dr. Millar and Dr. Houk address the efforts they make to insure continued funding of some of these programs by grantees. I think you well recognize from your position that the Federal Government is in a budgetary distress of its own with the deficit approaching $70 billion for fiscal year 1975 and probably more for fiscal year 1976. So, it is not a question of the Federal Government having to balance the budget situation and being able to fund these programs, all the programs which we have aspirations for in this country.

Mr. **Florio.** I suppose the answer there is priorities, I just happen to believe and suspect I would hope HEW believes the programs under their jurisdiction are high priority programs and we are talking about basic health considerations and I think perhaps should rank fairly high in terms of where we are going to put our money.

Mr. **Sopper.** I wish Dr. Millar and Dr. Houk to talk about efforts we are making to increase the State and local share on some of these projects.

Dr. **Millar.** I think, first of all, we have no documented assurances to offer you that State and local areas will provide increased funding. We have discussed the problems of our own financial situation at the various program meetings we hold with State and territorial epidemiologists and project directors. They are aware that we have financial problems as well.

With repect, for instance, to the immunization program, we have addressed the problem specifically in shifting our emphasis primarily to outbreak control and away from widespread immunization activities. This outbreak control approach is one which we think is probably more efficient. If one has to make choices between having widespread vaccination campaigns and epidemic control, we figure epidemic control is a more efficient and less costly way to approach the disease.

Certainly, sir, we would all like to have more money but it is a matter of priorities.

I will let Dr. Houk address the problem of how at least in the rat program there has been evidence of increased local support.

Dr. Houk. In 1969 when the urban rodent programs first began, 20 cities were initially funded and those cities contributed some 27 percent of the nearly $15 million that was expended that year.

Last year the same 20 cities that are being funded are contributing 63 percent of the amount of money which they got a very substantial increase in. Now, the 54 percent local increase that is referred to in the GAO report also includes new projects that are just beginning and are just beginning to develop the commitment funding. We have not asked for absolute assurance and a check before the project begins in order to fund it because there are many areas that are making very substantial efforts to increase their fundings who have significant problems and have a chance of achieving success.

Mr. Florio. If I could, perhaps you might be the gentleman to help me and I will conclude on this point, Mr. Chairman: If you might indicate to me the cause for the rather dramatic decrease in the authorization request for the lead poisoning program. Do you feel that is something that has not been successful or why such a big cut in that area?

Dr. Houk. To the contrary, I feel the lead based poisoning prevention program has been very successful. There is increasing commitment of local moneys. In some of the States there are other mechanisms that are now available to achieve the results that we are attempting to achieve such as "seed" money, title 10 money, EPSDT programs. In 49 of the States, lead screening is an approved EPSDT expenditure. In 17 of the States, it is a mandatory procedure to be done. I agree with you with some of the problems, however. In our lead projects we have people working together at the local level, the local project director, local health officer, and with the local EPSDT people to see how best these two efforts can be put together.

One of the major functions of the lead program is in its outreach efforts and in every instance when the child comes into a facility on his own or his parents' own, the frequency of elevated blood level is less than half the frequency when there is door-to-door effort made to reach the children to get them into the health care delivery system, not only for lead but for whatever else they may happen to need.

Mr. Florio. Is it appropriate to say that the two programs that had been categorical programs, the rodent control and the lead poisoning program, that with the broad scope of the approach that has to be taken, that is to say, the environmental consideration, community education, that that was the initial justification for separating them out of the other programs?

Do you feel anything has changed, that has to be addressed from a sanitation point of view from the outreach program? I am not sure I agree with their lumping in of those two separate programs with the rest of the Center of Disease Control functions. Can you give me some clear answer or clarification?

Dr. Houk. I believe the type of program management that is necessary to run these programs is the same as the other disease contr efforts; that one of the areas that has hampered us the most in t lead program is the inability to go to the State health department and to have to go to local areas directly. This has bypassed an agency of Government which could get some commitment and take some funds down from the State to the local areas in producing this. The same is true in rats. We are putting more and more emphasis on going to State health department activities and trying to carry down extra moneys from the State into the local areas and I think, in your own State, sir, there are much more State moneys going into urban rodent control than there are the Federal moneys that are limited to those six areas.

Mr. **Florio.** Thank you.

I am looking at Senator Kennedy's bill dealing with lead poisoning and there is a new definition, I believe it is a new definition, of what constitutes a lead-based paint. Are you familiar with this provision? Can you just amplify the significance of this—what are the ramifications, healthwise as well as perhaps commercially? Is it going to cause any difficulties for the paint manufacturers?

Dr. **Houk.** That issue is an important issue. It is an anticipatory issue for the future. The most important issue at the moment right now are the 30 million homes that already have excess lead on the interior but the issue of percentage of lead in paint which the Senate has agreed as it relates primarily to new lead in the cans. 0.06 was supposed to be the permissible level, unless the Chairman of the Consumer Product Safety Commission said a level higher—but not to exceed 0.5 percent was all right.

HEW is on record in several places as recommending the 0.06 not because 0.06 is a magic number but because it is safe, it is achievable, it is enforceable, and it has a safety factor of tenfold over 0.5.

Mr. **Florio.** What does the industry have to say? Does it have any feeling?

Dr. **Houk.** I think the industry would—unless I am misquoting them—like to keep it at 0.5. However, it has surveyed the situation and the Consumer Product Safety Commission indicates more than 75 percent of the interior paint is already at 0.06 or less.

Mr. **Florio.** Thank you very much.

Mr. **Preyer.** Thank you.

I wish to follow up on Mr. Florio's general budgetary comments and limit it to the field of immunization.

Your budget for fiscal year 1975 in immunization is $6.4 million. I understand that 1976 is $4.9 million. I must say I find the excruciatingly careful attention given to the budget in the health field as compared to something like the defense budget a little hard to understand. I would say it would seem to me in the health field like this is one area where if we err, it should be on the side of generosity rather than the other way.

I understand that you have got a program in a five-State area where you are trying to eliminate measles—Indiana, Michigan, Ohio, Wisconsin—some other State, for which I commend you. But my question is, why limit it to a five-State area?

Dr. Carter has pointed out we have eliminated smallpox in the world. Here we are trying to eliminate measles, which we know how to eliminate in a five-State area. Why don't we go at it a little more vigorously than that?

Dr. **MILLAR.** Mr. Chairman, thank you for the kind and true words about smallpox eradication. I think it has personally been very gratifying for me to be involved in this over the years and it is true at this moment only Ethiopia has any active cases. I think Bangladesh is——

Mr. **CARTER.** I believe, if you will excuse me, Eritrea—which is of course, Ethiopia. But there has been an epidemic in Bangladesh and in parts of India and I do not believe it is contained yet.

Dr. Henderson, I believe, is in charge of that at the World Health Conference or was.

Dr. **MILLAR.** Yes.

Mr. **CARTER.** He has done a magnificent job on it.

Dr. **MILLAR.** I was just going to lead into the matter about the measles activity in our region V which encompasses the States the chairman named. This attempt on our part is a direct followup of CDC involvement in the global smallpox eradication program. We have tried to take some of the methods that have been so successful and apply them to measles control, and the reason we are only doing this in a 5-State area is that the diseases are epidemiologically different. Measles is much more infectious than smallpox and, therefore, spreads faster; we are not sure that the same methods that have been so dramatically successful with smallpox will, in fact, contain measles. So we initiated this activity on a pilot basis to study whether or not these techniques will be successful against measles.

I might say a word or two about the techniques. What is involved basically is: (1) An active search, that is, instead of waiting for measles to be reported, we actually have people calling various health care deliverers asking the question, "Have you seen measles this week?" (2) We then respond to any suspicious reports with an immediate field investigation followed by a rapid defining of those really at risk, that is, who may have had contact with the patient; what are the groups that this patient is involved in, such as schools or day care centers or boy scout troops; and (3) then rapid immunization of all those people thought to be at some risk.

Obviously, this is different from the usual approach of immunizing a whole community or part of a community. It is an attempt to be as specific as possible in interrupting transmission, but, Mr. Chairman, we do not know that this is really going to work as well for measles, hence we are looking at it and if it does work, then we certainly would like to expand the concept elsewhere.

Mr. **PREYER.** I had the occasion to go to the World Health Organization Conference in Geneva and had a full briefing on the way, that this program has worked and that there is just one country left, I think it is Bangladesh, that has cases of smallpox. Measles, too, is something that we should be striving to immunize, but I am not sure we are going to. It will take a major Public Health Service effort, and I just think that is something that we are going to have to realize is costly, that it is going to be costly in this country because we have not got the same public health commitment that many other nations have.

We have made it more private. Our whole medical service delivery system is not what it should be in terms of the public health commitment, in my opinion. So that, though the present effort is commendable, I think it is desirable, I think we may well end up, if you are going to reduce it to dollars and cents, financing a system that is going to be more costly than total immunization, and I assume HEW is costing these approaches out and investigating the ramifications of both approaches. I think that is commendable, if they are.

But I would caution you not to approach it from a sheer cost-saving standpoint. By virtue of not having wide-scale immunization, you are going to save money but not achieve the same thing that has been achieved in the smallpox effort.

Dr. MILLAR. One of the objectives of our trial in region V is to ascertain what it costs to do this kind of approach. We should remember that we have had widespread community immunization programs in the past, and we have never been very successful in getting more than 8 out of 10 people immunized, especially in central cities as we have talked about before, where getting people immunized is a tough problem. So, mass campaigning has its difficulties. To really get 100 percent of the susceptible people immunized would, I think, be prohibitively expensive because in some areas it would take a one-on-one approach in each instance. That would be very costly.

If we had the best of all worlds, we would like to do both mass immunization and epidemic control.

Mr. PREYER. Thank you.

Dr. MILLAR. I hasten to emphasize that we are not discontinuing routine immunization. Our policy is to emphasize all opportunities to make immunization efforts more efficient by being selective of those to be immunized. We are emphasizing those at highest risk.

Mr. PREYER. Like Dr. Carter and Mr. Florio, I was impressed with Dr. Henderson and the World Health Organization and what Dr. Sencer and you are doing at the Communicable Disease Center and would like to see you unleased.

When do you think you will have a report in this five-State study, and recommendations on the basis of it?

Dr. MILLAR. We have already been involved in about four or five epidemics, and we have encouraging results. In those areas where the technique has been fully implemented, the response seems to be about as good as what we have seen overseas with the control of smallpox epidemics.

Now, if that holds up throughout the measles transmission season, which has approximately 6 or 8 more months to run its course, then I think we ought to have something firm to say next spring. However, it really depends on our findings.

Mr. PREYER. I think this committee would be interested in your results.

I understand in southwest Michigan right now there has been an outbreak. How many children do you estimate might be stricken in that area with measles?

Dr. Millar. Sir, I do not have figures on that. I would be glad to supply them for the record, but I do not have them with me.

Mr. Preyer. I think that would be helpful if we could get that figure for the record and perhaps an estimate of what the cost of that might be and how many children might be hospitalized.

[The following information was received for the record:]

MEASLES IN SOUTHWESTERN MICHIGAN, NOVEMBER 20, 1975

The measles epidemic in southwestern Michigan began August 10, 1975, and is still in progress. All of the data presented here should be regarded as preliminary.

Scattered cases of measles have been reported from several counties in the Northern and Eastern Regions of the State. As of this date, none of these have led to epidemics of the degree noted in the Southwest portion of the State.

The initial cases occurred in families of migrant workers. Measles has subsequenlty spread to 18 schools in five different counties—Allegan, Berian, Cass, Kent, and Ottowa. A total of 170 cases have been reported or discovered through epidemiologic investigation since August 10, 1975. The attack rate for these counties in the past month has been 55.7 per 100,000 persons less than 18 years of age. Most cases have been in elementary school children. A few outbreaks have occurred in Junior High and Senior High Schools. Preschool age children have made up a small minority of cases.

Eighteen schools have had measles cases reported. The attack rate for each school has been low with the highest reported being 3.81% in the Howard Ellis School in Cass County. The 1974 school entry survey revealed an average of 9 percent susceptibles for the entire five-county area, with a range of 6–15 percent. Attack rates for known susceptibles in the schools have not yet been calculated. They are estimated to range from 10–75 percent.

Control efforts in the form of school based immunization programs have been carried out in each of the schools where measles has occurred. Efforts were made to identify and immunize all of the susceptibles at the time of the program. All data have not yet been analyzed and the degree to which this has been successful has not yet been determined. An active search system has been established in the area which has improved reporting efficiency. In addition, efforts are in progress to identify all susceptibles in all of the remaining schools in the area. Vaccine will be delivered to susceptibles as rapidly as possible.

The outbreak is not yet clearly under control. However, the number of new cases is declining. Based on the attack rates thus far and estimates of the present immunity levels in the affected communities, the outbreak might continue for two or more generations and total over 250 cases.

To date, five cases have required hospitalization. One developed pneumonia and recovered completely. We have not received the diagnosis of the other four, more recent, hospitalizations. The cost for medical care and hospitalization to date in this outbreak excluding the four recent hospitalized cases is estimated at $10,000.

Mr. Preyer. We have had reports in the Washington Post recently or the Star that there was an arbitrary cutback in Federal immunization grants to Maryland, $270,000, 1975, to $158,000; Virginia from $234,000 to $130,000; District from $235,000 to $100,000. I would like to ask for the record if we could get a list of all of the States' cutbacks rather than taking the time right now. I assume the situation is about the same in all States as in these three that we cited.

Dr. Millar. We can provide you that list, sir, by State, for funding levels from 1972 through 1976. If there are some specifics, we could actually provide those now; otherwise, we can give the whole list.

Mr. Preyer. I hope you will provide those for the record. We are running out of time here now.

[The following information was received for the record:]

COMPARISON OF 1975 AND 1976 GRANT AWARDS IMMUNIZATION PROJECT GRANTS

State	Fiscal year 1975 award	Fiscal year 1976 [1] award	Difference 1976 over 1975
Alabama	128, 947	97, 992	−30, 915
A laska	40, 213	33, 800	−6, 475
Arizona	96, 871	85, 000	−11, 813
Arkansas	81, 102	59, 776	−21, 321
California	538, 584	424, 594	−113, 996
Colorado	80, 550	64, 119	−16, 430
Connecticut	78, 678	55, 720	−22, 958
Delaware	22, 946	34, 672	+11, 726
District of Columbia	94, 796	82, 738	−12, 058
Florida	186, 876	169, 035	−17, 841
Georgia	106, 590	112, 690	+6, 100
Guam	0	10, 000	+10, 000
Hawaii	35, 978	40, 133	+4, 155
Idaho	46, 717	39, 275	−7, 442
Illinois	280, 820	236, 160	−44, 660
Indiana	83, 743	70, 554	−13, 189
Iowa	48, 637	58, 683	+10, 046
Kansas	82, 804	54, 870	−27, 934
Kentucky	58, 340	50, 064	−8, 276
Louisiana	146, 721	106, 833	−39, 888
Maine	58, 876	28, 154	−30, 722
Maryland	18, 792	80, 307	+61, 515
Massachusetts	113, 063	105, 390	−7, 673
Michigan	248, 945	209, 210	−39, 735
Minnesota	101, 005	84, 764	−16, 241
Mississippi	144, 168	74, 964	−69, 204
Missouri	206, 105	170, 597	−35, 508
Montana	37, 950	32, 394	−5, 556
Nebraska	73, 089	50, 950	−22, 139
Nevada	72, 744	35, 026	−37, 718
New Hampshire	29, 723	28, 672	−1, 051
New Jersey	216, 146	125, 000	−91, 146
New Mexico	47, 790	40, 177	−7, 613
New York	317, 824	304, 110	−13, 714
North Carolina	135, 877	139, 060	+3, 183
North Dakota	30, 000	25, 138	−4, 862
Ohio	163, 767	137, 679	−26, 088
Oklahoma	71, 102	59, 770	−11, 332
Oregon	95, 181	63, 205	−31, 976
Pennsylvania	401, 035	202, 705	−198, 330
Puerto Rico	93, 890	80, 000	−13, 890
Rhode Island	54, 213	34, 196	−20, 017
South Carolina	124, 845	67, 125	−57, 720
South Dakota	53, 249	34, 976	−18, 273
Tennessee	149, 197	125, 430	−23, 767
Texas	313, 378	263, 144	−50, 234
Trust Territory	21, 899	24, 047	+2, 148
Utah	60, 382	33, 156	−27, 226
Vermont	36, 968	34, 968	−2, 000
Virgin Islands	38, 895	22, 000	−16, 895
Virginia	129, 431	80, 158	−49, 273
Washington	89, 751	75, 450	−14, 301
West Virginia	10, 000	54, 950	+44, 950
Wisconsin	92, 665	77, 903	−14, 762
Wyoming	16, 142	18, 917	+2, 775
Total	6, 108, 000	4, 910, 400	−1, 197, 600

[1] Some fiscal year 1976 awards are estimated.

Note: In a few instances the 1976 award is greater than the 1975 award. In those projects there were unusually high balances from prior year awards carried forward into 1975 as a result of the restoration, late in 1974, of funds which had been withheld in 1973.

Mr. PREYER. I was going to ask one other question which might be something you want to submit for the record, and that is, how many cases of measles do you anticipate this year?

Dr. MILLAR. We have had something over 22,000 last year, and we would hope, based on expectations of some success in region V, that it will be somewhat reduced this year, but I am reluctant to hazard a guesstimate as to what the total number will be.

Mr. CARTER. Thank you, Mr. Chairman. I have one question for page 3 of your bill.

Nothing in this Section shall be construed to require any state or any agency or political subdivisions of a state to have a Venereal Disease Program which would require any person who objects to any treatment provided under such a program to be treated or to have any child or ward of this treated under such a program.

Do you agree with that?

Mr. SOPPER. That is our proposal, Mr. Chairman. That has been in existing law for some time.

Mr. CARTER. You know that appears to be a pretty rough law. Suppose you see a woman who is 8½ months pregnant, ready to deliver, and has a four-plus Wasserman and four-plus VDRL, and mucous patches in her mouth and in her vagina. You know she is going to deliver a syphilitic baby. What are you going to do about it, just going to let her do that? Perhaps that was a poor analogy.

Dr. MILLAR. Sir, you have hit on a very real and poignant personal problem that we face with congenital syphillis. Most cases of congenital syphilis occur as a result of situations in which we never had the first chance to make a diagnosis of syphilis on the mother before she delivered the baby. Unfortunately, there are a few cases where the mother has made a prenatal visit, but the diagnosis was not discovered. If we were to encounter somebody in this situation, we would, of course, try with all possible vigor to reason with that person and have them treated. But when it comes right down to outright force, we try to avoid it.

Mr. CARTER. What happens to these children, these syphilitic children, when congenital syphilis is prevalent; what is the triad?

Dr. MILLAR. Probably about half of them die either in the uterus or shortly after birth, and many of the remainder have rather severe sequelae.

Mr. CARTER. The heart condition, hernia and eye condition.

Dr. MILLAR. Yes, sir.

Mr. CARTER. Also the teeth, pegged teeth and so on that go with that. It seems to me that this is legislation which would be better left out, a provision such as this—I think the law should require that anyone with syphilis be treated, particularly in an infectious stage, and such laws have been enforced in some of our States.

Dr. MILLAR. I do not think it would really bother me a great deal if the section of the law to which you refer was not there.

Mr. CARTER. I know, because I have done it. Thank you.

Mr. PREYER. Thank you. We have one other witness, and I hope we can finish before the first quorum call. I had one other question. Perhaps I could put it to you, and you could give us some answer for the record. The CDC advertised, as I understand it, for 2.1 million single dose vaccines. Dow bid 89 cents a dose but could only provide 1.6 million doses. They could not do all this by September 15, the deadline. Merck bid $1.19, and the contract was given entirely to Merck. The question is, if you had split it by giving Dow the amount it was able to have produced, would it not have saved the Government $480,000? That is a question that I think for the record we ought to have some answer to.

Dr. MILLAR. We will supply it for the record, sir.

[The following information was received for the record:]

VACCINE PURCHASING

The Veterans Administration requested quotations on a contract for Live, Attenuated Rubeola-Rubella Vaccine for the period June 15, 1975 through June 14, 1976, with delivery to be made 15 days after receipt of order. Quantities and specifications are indicated below:

Estimated maximum quantity 3 million doses:	*Doses*
Single-dose vital w/syringe and needle	2, 100, 000
10-dose vials	525, 000
50-dose vials	375, 000
Guaranteed minimum	600, 000
Estimated maximum monthly usage	400, 000

Merck Sharp & Dohme and Dow Chemical Company, the two licensed manufacturers, bid on the contract. Merck submitted a bid meeting all the requirements of the contracts including quantity and delivery schedule. Dow Chemical Company submitted a bid only on the single-dose vaccine (2,100,000 doses) with the following contingencies. "Maximum quantity available after September 15, 1975, 1,500,000 doses. Total number of doses bid—1,600,000." The contract offices contacted Dow further to determine if they could improve on their productions to meet quantity demands and delivery schedule requirements. Dow advised that they could not improve their situation.

According to the DOW bid, they could only provide 100,000 doses of the vaccine prior to September 15, 1975. The summer period preceding the start of the school year was expected to be a period of extensive ordering since school systems normally order vaccines prior to the school year. To accept DOW's proposal would have delayed the immunization program in the school systems.

If the award was split, a new request for bid would have been issued, and Merck Sharp & Dohme would have undoubtedly increased their unit price as the result of the lower level of expected orders. Any savings accruing from DOW have been offset by higher unit prices from Merck Sharp & Dohme, who would be called upon to supply that portion of vaccine which DOW was unable to provide.

Although DOW's price per dose bid was lower than Merck's, their bid was determined to be non-responsive because they could not meet the supply schedule in terms of time and quantity, and the award was made to Merck Sharp & Dohme.

Mr. PREYER. Thank you, sir. We appreciate your being with us today and thank you very much for your testimony.

Mr. Samuel R. Knox, director of the American Social Health Association. I apologize for getting to you so late.

STATEMENT OF SAMUEL R. KNOX, DIRECTOR, AMERICAN SOCIAL HEALTH ASSOCIATION

Dr. KNOX. Mr. Chairman and members of the subcommittee, I am Samuel R. Knox, director of the American Social Health Association. At the invitation of the subcommittee, I am testifying on behalf of the association. The American Social Health Association, founded in 1912, is the only national voluntary nonprofit agency dedicated to the elimination of venereal disease as a major social health problem through a comprehensive program of research, information, and education and citizen action.

Rather than dwell on the tragic and terribly costly problem of epidemic venereal disease, I wish to focus what time I have with you today on the substance of what the American Social Health Association considers an appropriate legislative response to these horrendous disease conditions. Please note that the specifics regarding the magnitude, tragedy, and economic implications of the venereal disease epidemic are clearly and accurately articulated in our publication "Today's VD Control Problem, 1975"[1] which I am attaching herewith for your later inspection and possible inclusion in the record.

The soundest legislative approach to the venereal disease problem should stem from and subsequently authorize and support the soundest public health approach to these diseases. The American Social Health Association submits that the soundest public health approach to epidemic venereal disease ultimately must address the key issues of diagnostic and treatment services, disease control and prevention, utilizing the best tools and methodologies available today, and research directed at refining the former two elements as well as seeking to develop the ultimate weapons, effective vaccines against these dreaded infections.

H.R. 8278, Mr. Rogers' series of amendments to the recently expired venereal disease authorization, comes very close to creating the ideal legislative approach to the venereal disease problem. We would, however, like to offer a number of suggestions that, if embodied in H.R. 8278, would further strengthen this already strong and progressive bill.

The broadening of the technical assistance provision of Public Law 92-449—subsection (a) of section 318—by H.R. 8278 is laudable. We wholeheartedly support this as a frank recognition of the interdisciplinary interplay that will be required to address the venereal disease epidemic.

The continuation of the research, demonstration, and training authority—subsection (a) of section 318—by H.R. 8278 is similarly worthy of praise. We are gratified to see that the authorized annual appropriation level of $7.5 million has remained unchanged. Regarding this authority and these sums, we find it unconscionable that the Federal VD control experts have never seen fit to take advantage of this progressive and potentially highly productive component of the law. It would seem to run counter to the most basic concepts of public health in light of the many problems and questions that face us which can only be addressed by research, pilot demonstration projects, and more intensive training. We urge this subcommittee to do all it can to help the Federal VD controllers to recognize their error in not employing all available resources to combat this rampaging epidemic.

Regarding the project grant authority (subsec. (d) of sec. 318) that enables such veneral disease prevention and control activities as screening, disease surveillance, contact tracing, and venereal disease information and education projects, we are happy to see it preserved by H.R. 827i. We suggest however, that the annual authorized appropriation be revised upward somewhat to permit the maintenance of present program levels—$28 million in fiscal year 1975—during fiscal years 1976, 1977, and 1978. We, therefore, recommend authorized appropriation levels of $30.240 million, $32.7 million, and $35.3 million for fiscal years 1976, 1977, and 1978, respectively. These higher levels will prevent inflationary erosion of the highly successful venereal disease prevention and control project grant program.

We note that H.R. 8278 repeals subsection (c) of section 318, the so-called formula grant authority whereby Federal moneys were to have been granted to State health authorities to assist them in providing and maintaining adequate public health programs for the diagnosis and treatment of venereal disease. Inasmuch as all States and many municipalities already have such clinical care programs, the obvious intention of this subsection was to have addressed the issues of quality and wider availability of such services. We are in basic agreement with the repeal of this subsection. We have some serious questions as to the ability of a formula grant mechanism to effectively address these issues.

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[1] May be found in the committee's files.

The fact that funds authorized by this susbsection were never requested leads us to believe that our concerns are shared by the Federal venereal disease experts as well. However, everyone in public health unanimously agrees that venereal disease clinical services are by and large deplorable and must be improved. We must not forget this fact. We, therefore, urge this subcommittee to direct these Federal venereal disease experts to explore various methodologies and strategies for improving venereal disease clinical services via already existing authorities to conduct studies, pilot projects, and demonstrations to test ways of improving venereal disease prevention and control.

We further urge that the findings of such explorations be reported to this subcommittee so that a legislative approach to this vital component of the total venereal disease control game plan can be intelligently formulated at a later date.

Lastly, we wish to make one additional observation and one final suggestion. Prior to 1972, the exclusion of gonorrhea from the legislative approach to venereal disease effectively permitted that infections unchecked spread. The result was a gonorrhea epidemic of unparalleled proportions. Now, as then, there are disease entities which, by virtue of their clinical impression, mode of transmission and high levels of incidence are not dissimilar to the analogous situation with gonorrhea. They are the sexually transmitted diseases—genital herpes, nongonococcal urethritis and trichomoniasis to mention a few. These diseases have been grossly neglected for too long—with tragic results. We suggest that as the incidence and consequences of gonorrhea finally mandated our attention in 1972, the incidence and consequences of these other sexually transmitted diseases similarly mandate our attention now.

We, therefore, strongly recommend that H.R. 8278 be amended to provide for a redefinition of venereal disease to include all sexually transmitted diseases found to be of national significance, in addition to syphilis and gonorrhea.

Mr. Chairman, I thank you for the opportunity of presenting the thoughts and suggestions of the American Social Health Association. If there is anything further you require of us I am only too eager to assist.

Thank you again.

Mr. PREYER. Thank you very much, Mr. Knox.

Mr. FLORIO. I have no questions. I would just make a comment. The gentleman has expressed his views as to the existing effectiveness of the program with certain limitations. I really ask a rhetorical question: What do you think would happen if the $28 million authorization and appropriation were reduced to $20 million in accordance with the administration's request?

Mr. KNOX. It would be disastrous.

Mr. FLORIO. Thank you.

Mr. PREYER. Thank you very much Dr. Knox, for a very straightforward and clear presentation. I think your points are well made and your remarks on funding are realistic and we appreciate your testimony.

Dr. Carter, do you have any questions of Mr. Knox?

Mr. CARTER. I missed the gentleman's testimony which I regret very much. Probably Mr. Florio has some questions?

Mr. PREYER. Mr. Florio has already questioned and we were all a little briefer than we would like to be because I think we are about to come up on a quorum call shortly.

Mr. CARTER. In scanning this, I find nothing with which I disagree.

Mr. PREYER. That is a good, clear, brief statement. Thank you, Mr. Knox.

Mr. KNOX. Thank you.

Mr. PREYER. We will adjourn until tomorrow at 10 o'clock on the same subject matter.

[Whereupon, the subcommittee adjourned to reconvene on Tuesday, November 4, 1975 at 10 a.m.]

NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

TUESDAY, NOVEMBER 4, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommitee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. Rogers. The subcommittee will come to order, please.

We are continuing hearings on title II of H.R. 8278, the National Health Education and Disease Prevention Act of 1975, and our first witness today is Dr. David H. Carver, American Academy of Pediatrics Committee on Infectious Diseases, Department of Pediatrics, Johns Hopkins Hospital, Baltimore.

Dr. Carver, we welcome you to the committee and you may proceed as you desire.

STATEMENT OF DAVID H. CARVER, M.D., MEMBER, COMMITTEE ON INFECTIOUS DISEASES, AMERICAN ACADEMY OF PEDIATRICS

Dr. Carver. Thank you, sir.

Mr. Rogers. I see you have members of your family here.

Dr. Carver. Yes, my daughter accompanied me.

I am a pediatrician and a member of the Committee on Infectious Diseases of the American Academy of Pediatrics. The American Academy of Pediatrics is an organization of 17,000 board certified pediatric specialists devoted to improvement in the care of children with a particular emphasis on the use of preventive medicine as the most efficient means of dealing with disease. I am also professor of pediatrics at Johns Hopkins University School of Medicine and the director of the division of infectious diseases in the Department of Pediatrics at Johns Hopkins.

The American Academy of Pediatrics strongly endorses the provisions of the Disease Prevention and Control Amendments of 1975 as it has endorsed all previous Federal legislation supporting effective immunization programs against communicable diseases.

In support of this act I want to first emphasize that we have currently available vaccines that are very effective in preventing diptheria, pertussis (whooping cough), tetanus, poliomyelitis, measles and mumps. These diseases are no longer seen by physicians who deal with well-immunized populations. As an example of vaccine efficacy, the data enclosed from the 1970 neurotropic surveillance report indicates that the number of patients in the United States with paralytic poliomyelitis has decreased from 5,500 patients in 1959 to 32 patients in 1970. The current best data for 1974 indicate that four cases of paralytic poliomyelitis occurred that year.

From "NEUROTROPIC DISEASE SURVEILLANCE 1970 SUMMARY"

Figure 1 "BEST AVAILABLE PARALYTIC POLIOMYELITIS CASE COUNT," BY YEAR, UNITED STATES, 1958-1970

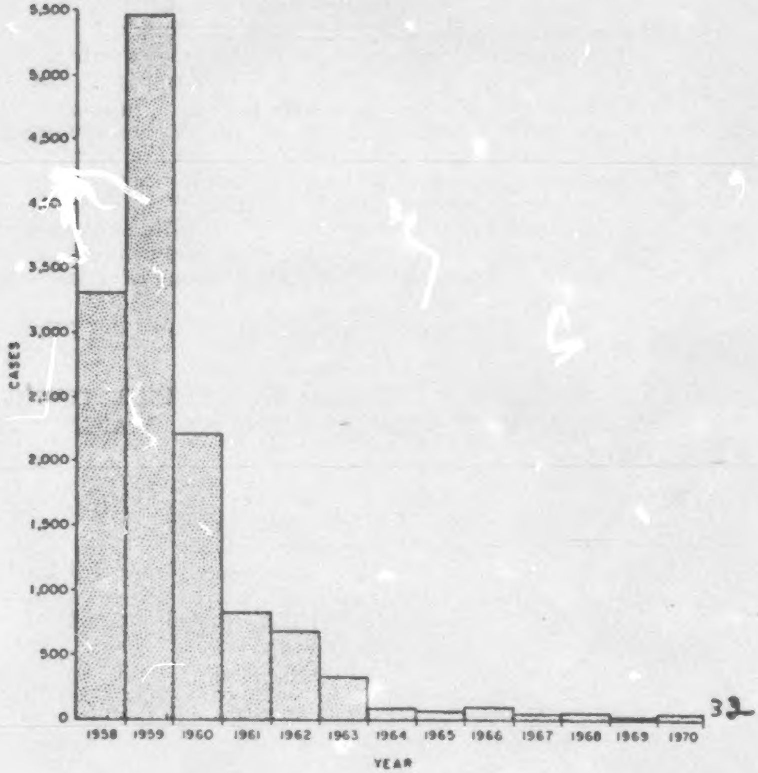

FIGURE 1

The poliomyelitis seen in recent years has included outbreaks in Texas among unimmunized indigent patients and an outbreak in a Connecticut school run by the Christian Science Church where the students were not immunized prior to the outbreak.

Another example of vaccine efficacy has been the use of measles vaccine. In the enclosed paper by Witte and Axnick [see p. 164] of the CDC studying the benefits of 10 years usage of measles vaccine in the United States, it is noted that each year prior to the licensure of live measles virus vaccines (in 1963) an estimated 4 million cases of measles, 4,000 cases of measles encephalitis and 400 measles-associated deaths occurred in the United States. These authors calculate that by the use of measles vaccine between 1963 and 1972 over 23 million cases of measles were averted, 2,400 lives were saved and 7,900 cases of mental retardation were prevented. During this period 58.5 millions doses of measles vaccine were distributed at an estimated cost for vaccine production, distribution, administration and promotion of $3 per dose.

These authors estimated that after deduction of the cost of the vaccine used, $1.3 billion in health care costs were saved by preventing 23 million cases of measles and the complications involved. In addition to this, the humanistic element of preventing disease, death, and retardation should be emphasized as a fact that cannot be measured in dollars.

In contrast to the fields of cancer and heart disease where basic research is needed to develop sufficient understanding of the diseases to lead to effective methology for prevention, we currently have effective means for preventing the communicable diseases mentioned above.

The second point I want to emphasize is that these vaccines are not currently being made available to the entire U.S. population susceptible to the communicable diseases involved. As can be seen in the 1974 communicable disease survey of the 1 to 4 year olds in the United States (by the Center for disease control), 63 percent had the recommended poliomyelitis immunization; only 74 percent had the recommended immunization against diphtheria, pertussis and tetanus; and only 65 percent were immunized against measles (table 1). Table 6 indicates that the children living in central cities were less well-immunized than other children and tables 7, 8, and 9 indicate that the nonwhite population was less well-immunized than the white population. With this data, it appears obvious that greater effort is needed to inmunize the children at risk and particular emphasis should be placed on immunizing the indigent population. not only are more vaccine funds needed for the indigent population than are currently available but also efforts have to be made to motivate the parents of these children to have their children immunized. I am particularly pleased that the bill under consideration has provisions for "developing an awareness in those persons most susceptible to the diseases referred to of appropriate behavior and preventive measures (including immunization)."

TABLE 1.—PERCENT OF POPULATION 1 TO 4 YEARS OF AGE WITH SPECIFIED DOSES OF POLIO, DIPHTHERIA TETANUS-PERTUSSIS (DTP), MEASLES, AND RUBELLA VACCINES, UNITED STATES 1964-74

Year	Polio, 3 plus doses	DTP, 3 plus doses	Measles, 1 dose	Rubella, 1 dose
1964	78.6	76.0	24.0	(1)
1965	73.9	73.9	33.2	(1)
1966	70.2	74.5	45.5	(1)
1967	70.9	77.9	56.4	(1)
1968	68.3	76.5	58.8	(1)
1969	67.7	77.4	61.4	(1)
1970	65.9	76.1	57.2	37.2
1971	67.3	78.7	61.0	51.2
1972	62.9	75.6	62.2	56.9
1973	60.4	72.6	61.2	55.6
1974	63.1	73.9	64.5	59.8

[1] Rubella vaccine was licensed in June 1969.

Source: U.S. Immunization Surveys, 1964-74.

TABLE 6.—PERCENT OF POPULATION 1 TO 4 YEARS OF AGE WITH HISTORY OF SPECIFIED DOSES OF POLIO, DIPHTHERIA-TETANUS-PERTUSSIS (DIP), MEASLES, AND RUBELLA VACCINES BY STANDARD METROPOLITAN STATISTICAL AREA (SMSA) CENTRAL CITIES AND REMAINING SMSA, UNITED STATES 1969-74

Vaccine and year	SMSA component area	
	Central cities	Remaining SMSA
Polio (3 plus doses):		
1969	62.4	72.5
1970	61.0	70.8
1971	63.6	71.6
1972	57.5	68.3
1973	58.0	66.6
1974	60.0	68.1
DTP (3 plus doses):		
1969	73.8	87.6
1970	68.9	80.7
1971	71.9	82.9
1972	68.5	81.7
1973	67.4	79.5
1974	69.5	77.9
Measles:		
1969	57.3	66.6
1970	55.2	61.7
1971	59.2	64.7
1972	59.8	66.0
1973	59.6	65.1
1974	6[illegible].5	68.5
Rubella: [1]	[illegible]8.3	39.2
1970	[illegible]1.6	52.8
1971	56.8	58.7
1972	56.9	58.6
1973	61.1	62.3
1974		

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[1] Rubella vaccine was licensed in June 1969.

Source: U.S. Immunization Surveys, 1969-74.

TABLE 7.—PERCENT OF POPULATION WITH SPECIFIED DOSES OF POLIO VACCINE IN CENTRAL CITIES BY AGE AND RACE, UNITED STATES 1972-74

Year and race	Age group	Population (thousands)	3 plus doses	2 plus doses	No doses
1972:					
White	1-4	2,936	64.2	78.6	10.1
	5-9	3,586	(80.4) 69.9	(88.3) 80.2	3.8
All other races	1-4	1,390	43.2	61.7	14.9
	5-9	1,620	(61.9) 52.1	(78.1) 70.9	4.4
Total	1-4	4,326	57.5	73.2	11.6
	5-9	5,206	(74.6) 6.43	(85.2) 77.3	4.0
1973:					
White	1-4	2,783	66.3	79.8	10.9
	5-9	3,467	72.8	82.4	8.9
All other races	1-4	1,305	40.3	58.9	24.4
	5-9	1,679	63.4	76.7	13.3
Total	1-4	4,088	58.0	73.1	15.2
	5-9	5,146	69.7	80.5	10.4
1974:					
White	1-4	2,696	66.2	79.5	9.3
	5-9	3,344	75.2	82.8	9.0
All other races	1-4	1,288	47.0	64.8	21.1
	5-9	1,596	60.7	76.3	11.8
Total	1-4	3,984	60.0	74.8	13.1
	5-9	4,941	70.5	80.7	9.9

Note: The numbers in parenthesis represent the influence of the inactivated polio vaccine in the 5 to 9 year old cohort in 1972. Since less than 0.8 percent of the total polio vaccine distributed during the period 1970-73 was inactivated polio vaccine, information was obtained regarding only oral polio vaccine in the 1973 and 1974 surveys.

Source: U.S. Immunization Surveys, 1972-74.

TABLE 8.—PERCENT OF POPULATION WITH SPECIFIED DOSES OF DIPHTHERIA-TETANUS-PERTUSSIS (DTP) VACCINE IN CENTRAL CITIES BY AGE AND RACE, UNITED STATES 1972-74

Year and race	Age group	Population (thousands)	4 plus doses	3 plus doses	No doses
1972:					
White	1-4	2,936	34.9	74.7	7.1
	5.9	3,586	61.6	84.2	3.0
All other races	1-4	1,390	24.7	55.3	14.5
	5-9	1,620	48.5	72.2	4.5
Total	1-4	4,326	31.7	68.5	9.5
	5-9	5,206	57.5	80.5	3.4
1973:					
White	1-4	2,783	33.2	72.2	5.0
	5-9	3,467	62.5	82.1	3.2
All other races	1-4	1,305	26.6	58.5	10.0
	5-9	1,679	51.4	74.8	4.9
Total	1-4	4,088	31.9	67.4	6.6
	5-9	5,146	58.9	79.7	3.8
1974:					
White	1-4	2,696	37.7	74.3	4.5
	5-9	3,344	67.2	86.4	3.7
All other races	1-4	1,288	29.3	59.4	10.1
	5-9	1,596	52.4	74.4	4.4
Total	1-4	3,984	35.0	69.5	6.3
	5-9	4,941	62.4	82.5	3.8

Source: U.S. Immunization Survey, 1972-74.

TABLE 9.—PERCENT OF POPULATION WITH HISTORY OF MEASLES VACCINE, AND MEASLES INFECTION AND/OR VACCINE IN CENTRAL CITIES BY AGE AND RACE, UNITED STATES 1972-74

Year and race	Age group	Population (thousands)	History of vaccine	History of infection and/or vaccine
1972:				
White	1-4	2,936	62.1	65.4
	5-9	3,586	71.6	80.9
All other races	1-4	1,390	54.9	61.1
	5-9	1,620	59.8	72.5
Total	1-4	4,326	59.8	64.0
	5-9	5,206	67.9	78.3
1973:				
White	1-4	2,783	63.3	66.5
	5-9	3,467	70.9	80.6
All other races	1-4	1,305	51.7	56.1
	5-9	1,679	60.4	73.0
Total	1-4	4,088	59.6	63.2
	5-9	5,146	67.5	78.1
1974:				
White	1-4	2,696	66.2	68.0
	5-9	3,344	74.3	81.6
All other races	1-4	1,288	54.6	58.4
	5-9	1,596	66.9	74.9
Total	1-4	3,984	62.5	64.9
	5-9	4,941	71.9	79.4

Source: U.S. Immunization Survey, 1972–74.

The fourth and final point I want to emphasize concerning the vaccination program is that the provisions in the bill for evaluating the efficacy of the programs are essential. Ongoing continuous studies concerning the quality and duration of immunity conferred by current and future vaccines are needed so that the best possible vaccines are used. As an example, a new vaccine against rubella (German measles) currently used in Europe is about to be licensed in the United States. This vaccine may be more effective than the ones currently being used in the United States and we need the data to determine this. We also need continuing data as to the efficacy of the different current approaches using rubella vaccines in the prevention of congenital rubella. Everything possible should be done to prevent the occurrence of mental retardation, cardiac anomalies, cataracts, deafness, and growth problems associated with congenital rubella, as well as preventing the increased fetal wastage associated with congenital rubella. Encouraging data has been reported by CDC concerning the current U.S. rubella vaccine program but more data is needed.

With respect to tuberculosis, which is also mentioned in the act, we have effective drugs which can prevent the serious complications of this disease, such as meningitis. However, funds are needed to administer programs that identify the specific population at risk and make the drugs available to them. Here again, particular attention has to be given to the indigent population since a disproportionate number of the tuberculosis cases seen occurs in this population.

Rh disease is also listed in the act. Here the use of special antibody given immediately after delivery of a child can prevent a woman from developing antibodies against this Rh factor and protect her future children from the development of jaundice and the neurologic damage associated with jaundice. Again, the specific population at risk has to be identified and the appropriate treatment given to prevent disease.

As usual, the indigent population are those least likely to receive appropriate preventive therapy in this situation.

It is clear that the diseases under consideration can be prevented at this time if the appropriate programs are funded.

Particular emphasis has to be placed on reaching the indigent population who do not receive the same quality of preventive medicine care involving immunization and other approaches as do upper socioeconomic groups.

The Academy approaches the effort toward the coordination of disease prevention and control programs under H.R. 8278. However, by definition, this bill addresses two main categories of programs: those for disease prevention amenable to immunization programs, and those for disease control amenable to monitoring and treatment. Because of their distinctive features, we would strongly recommend that there be specific authorizations for appropriation for the communicable disease prevention program and separate authorization for the disease control program. This would assure adequate visibility for each component program and obviate competition for funds between the programs.

The issue of lead poisoning has also been included under the current bill but merits special consideration. If left as written, significant components of the current Lead-Based Paint Poisoning Prevention Act would be in jeopardy. We would agree with the committee that lead poisoning is appropriately placed under this bill, but urge that because of its unique properties, it be addressed under a separate title. To further delineate the problems involved with lead poisoning, I am appending a copy of the Academy's recent testimony on this issue [see p. 168].

You are well aware October 1975 was the third annual "Immunization Action Month" and the academy has played an important role in gaining professional support for these activities. A great deal must be done, for both the public and private sectors have slacked off somewhat in assuring that all children are adequately immunized. Therefore, the academy strongly recommends that at least $20 million be specifically authorized for immunization programs for next year as studies indicate that this is the amount needed for a program of sufficient scope to initate a realistic attempt at eliminating the preventable diseases from the United States. It will be important to continue funding at realistic levels for subsequent years for the program to be successful. As noted in the measles example given earlier, funds spent on immunization involved an extraordinarily good cost-benefit ratio and in the long run save the country money by preventing disease and the much greater cost of caring for children with diseases and their complications.

Another example is that of congenital rubella, where estimates indicate that $2 billion has been spent in caring for those children who had congenital rubella during the 1964 outbreak. No medical procedure has a better cost-to-benefit ratio than does immunizations.

Admittedly, preventive medicine is hard to sell. Hence, all barriers to immunization must be removed. The committee in infectious diseases of the American Academy of Pediatrics is concerned about the potential adverse effects of the *Reyes* v. *Wyeth* decision on immunization programs and is currently exploring possible mechanism whereby immunization programs would not be hindered by this court decision. We welcome discussion with the members of this committee of the Congress concerning this important problem.

In conclusion, the American Academy of Pediatrics pledges the enthusiastic support of the pediatric community in joining with the Congress in attempting to eliminate from the United States in the near future those communicable diseases, such as poliomyelitis and measles, which are now completely preventable.

[The study and statement referred to follow:]

[From Public Health Reports]

THE BENEFITS FROM 10 YEARS OF MEASLES IMMUNIZATION IN THE UNITED STATES

(By John J. Witte, M.D., and Norman W. Axnick, M.S., U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Atlanta, Ga.)

Dramatic reductions in the morbidity and mortality of disease may occur following effective immunization programs. For example, large areas of the world are now free from smallpox as a result of intensive vaccination efforts,[1] and epidemic poliomyelitis is no longer a major health problem in those countries with effective poliomyelitis immunization programs.[2] Extensive vaccination against measles in the United States has accounted for a sizeable reduction in the number of cases of measles, the cases of measles encephalitis and the deaths resulting from measles.[3] The humanistic benefits resulting from the prevention of these diseases are obvious. However, there are other benefits which are less obvious, particularly the economic benefits, which result from immunization. It is these economic benefits, translated into dollars, that the administrator of a health service can use to justify the seemingly high cost of vaccination programs and to raise the priority for the funding of vaccine preventable disease programs. The expression of the savings accrued by preventing disease in economic terms involves a new parlance for physicians and other health professionals. The benefits derived from immunization must be described in terms that can be added or subtracted. For example, they can be translated into the dollar value of savings of work days, savings of hospital admissions, savings of physicians' services and savings of other medical costs. The dollar value of these savings is particularly relevant today, as the costs of health services are increasing and the available public funds are limited.

Measles vaccination in the United States is an excellent example of the humanistic and economic benefits derived from immunization. Prior to the licensure of live measles virus vaccines in 1963, an estimated 4 million cases of measles, 4,000 cases of measles encephalitis and 400 measles-associated deaths occurred each year. Since licensure, approximately 60 million doses of vaccine have been distributed. This report analyzes the benefits, both humanistic and economic, of the first 10 years of measles vaccination in the United States.

METHODOLOGY

Our objective is to measure both the benefits and the costs resulting from measles vaccination in the United States. For the 10-year period 1963–1972, we estimated (1) the costs the nation would have sustained without immunization against measles and (2) the actual cost of measles. The difference between these costs represents the gross immunization benefit. In other words, (1) the estimated measles costs without immunization minus (2) the actual measles costs equal the gross benefit. To determine the net economic savings due to immunizations, the costs related to immunization must be considered. Thus, the gross benefits minus the costs of immunization equal the net benefits from immunization. Included in these immunization costs are moneys spent for the purchase of vaccine, the delivery of immunization services, and, if applicable, the cost of research and development.

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[1] World Health Organization: Weekly Epidemiologic Record. 49:9–11, Jan. 11, 1974.

[2] Drozdov S. Cockburn WC: Poliomyelitis in the Developed and Developing Countries. Proceedings of International Conference on the Application of Vaccines Against Viral, Rickettsial, and Bacterial Diseases of Man. Pan American Health Organization Scientific Publication 226: 163–170, 1971

[3] Center for Disease Control: Measles Surveillance Report No. 9. August 1973.

Research costs to develop and test measles vaccines were excluded from this analysis. The identification of expenditures for basic and applied research that contributed to the development of measles vaccines is difficult to measure accurately. We are also faced with the problem of determining the share of research costs applicable to the 1963–1972 time frame for the United States, considering the potential long-term use of the vaccine and the global distribution of vaccine.

The benefits associated with the immunization against measles include (1) medical care costs for physicians' services and hospital services, and the long-term institutional care for the retarded; and (2) the production lost as a direct result of morbidity and premature mortality. In this report, we have not included an estimate of the value of the social benefits associated with the school days saved, nor the humanistic benefits associated with the prevention of retardation, the prevention of premature death, and the suffering resulting from measles complications—encephalitis, otitis, and pneumonia.

The methodology by which the two components (costs and benefits) are estimated is detailed in our previous paper.[4] A discount rate of 4 percent was utilized to determine the present value of the benefits and costs which will occur in future years. This analysis assumes that the national immunization effort had no marked effect on the demand for medical care nor on the labor force.

SAVINGS IN MORBIDITY AND MORTALITY

The incidence of measles in the United States compared with the expected occurrence of measles without immunization is shown for the years 1963 through 1972 in Figure 1. During the first 3 years of vaccine availability (from early 1963 until mid 1966), a total of 15 million children were immunized (Table 1). The number of reported cases was reduced by 50 percent, and many believed that measles could be eliminated from the United States through intensive vaccination campaigns.

In October 1966, the Center for Disease Control, with the support of professional and voluntary health organizations, launched a national campaign to attempt to eliminate measles.[5, 6] This campaign emphasized community immunization programs, but also included intensified surveillance of the disease, control of measles outbreaks, and the establishment of continuing immunization programs for those children who were either reaching 1 year of age or entering school. These efforts resulted in a further decline of measles, to a low of 220,000 cases in 1968. Unfortunately, the impetus for the program was not sustained after the legislation providing the Federal funds specifically for the measles program expired in 1968. At that time, many States did not have sufficient money for the purchase of measles vaccine and continuing vaccination efforts were terminated by many health departments. The incidence of the disease then began to increase, to 530,000 cases in 1970 and to 850,000 cases in 1971. Federal money for measles vaccination programs again became available in the middle of 1971 and intensive immunization efforts were renewed. In 1972 the number of cases declined and in 1973 there were fewer cases than in 1972.

Without vaccine, between 4.0 and 4.5 million measles cases would have occurred each year. During this 10-year period, almost 24 million cases were averted (Table 2). Similarly, measles mortality also declined substantially. A total of about 2,400 lives were saved as a result of immunization (Table 2).

ECONOMIC SAVINGS

The annual benefits and costs of immunization against measles in the United States for the period 1963 through 1972 are shown in Figure 2. The costs appear to be relatively stable throughout this period. Included in the total costs for each year are the costs of vaccine production, distribution and administration as well as expenses related to promotional activities. The total cost is approximately 3 dollars ($3.00) per dose of vaccine. The economic benefits from vaccination are greater than the costs for every year, even 1963, the year the vaccine was first available. The annual benefits rise steadily during this period and now are substantially higher than the costs. These benefits can be expected to increase even further in the future (provided immunization of each new birth cohort continues at a reasonable level), because the benefits from immunization are additive. The proportion of immune persons in a population depends on the number of immunizations given in the past. As the proportion of immune persons increases, the potential for transmission of disease decreases because a smaller number of persons are capable of spreading infection. In this way, the immunity that inoculation against measles confers on susceptible populations increases as time passes. Additionally, every case of mental retardation averted and every death prevented provides an economic benefit for that individual's expected life span. That person will become a member of the work force and will contribute economically for many years and these benefits will accrue for those years.

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[4] Axnick, N. W.; Shavell, S. M.; Witte, J. J.: Benefits Due to Immunization Against Measles. Public Health Report 84:673–680, 1969.

[5] Sencer, D. J.; Dull, H. B.; Langmuir, A. D.: Epidemiologic Basis for Eradication of Measles in 1967. Public Health Report 82:253–256, 1967.

[6] Dull, H. B.; Witte, J. J.: Progress of Measles Eradication in the United States. Public Health Report 83:245–248, 1968.

A summary of health and resource savings due to immunization against measles is shown in Table 2. In addition to the cases averted and lives saved, there were 7,900 cases of mental retardation obviated, 709,000 years of normal and productive life preserved by preventing deaths from measles and the mental retardation following measles encephalitis. The savings of educational resources include 78 million days of regular academic schooling and, for the 7,900 mentally subnormal cases, substantial savings in special class or individualized schooling accrued.

The value of the net benefits achieved through immunization is $1.3 billion saved for the 10-year period.

SUMMARY

For many years, measles was regarded by many physicians as an unpleasant but relatively benign disease. These data reinforce the significance of the disease measles and the benefits of prevention. Because a number of costs of illness were not considered, this estimate of $1.3 billion in economic savings is a conservative one, particularly from a health care delivery viewpoint.

Information on the relative benefits from any preventive practice is of value to the administrator who must make decisions on the priorities for spending public moneys. Clearly, the benefits derived from measles immunization are impressive. Extensive use of vaccine has resulted in substantial savings of the nation's health resources and has allowed medical, educational, and economic resources to be released for other uses.

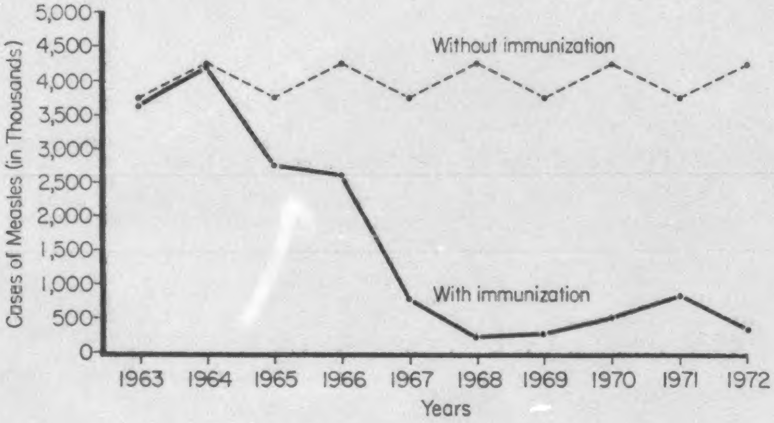
TABLE 1.—*Measles virus vaccine, total doses distributed, United States 1966–72*

Year:	*Doses (millions)*
1963	3.2
1964	3.8
1965	6.0
1966	7.9
1967	6.4
1968	5.3
1969	4.9
1970	4.5
1971	8.3
1972	8.2
Total	58.5

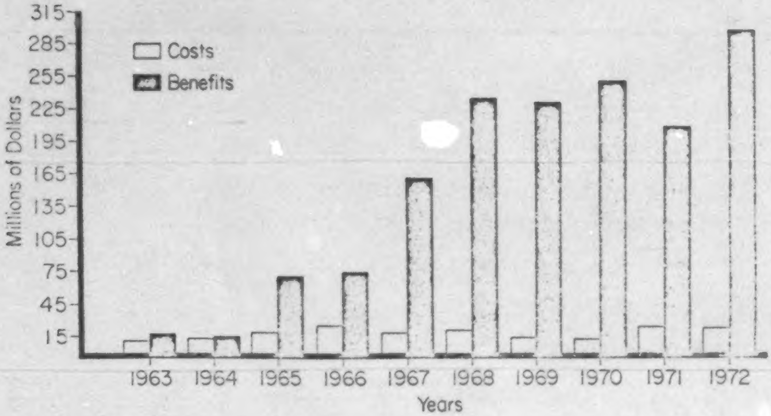
SUMMARY OF HEALTH AND RESOURCE SAVINGS DUE TO IMMUNIZATION AGAINST MEASLES, UNITED STATES, 1963-1972

Cases averted	23,707,000
Lives saved	2,400
Cases of retardation averted	7,900
Additional years normal and productive life by preventing premature death and retardation	709,000
School days saved	78,000,000
Physician visits saved	12,182,000
Hospital days saved	1,352,000

MEASLES INCIDENCE IN THE UNITED STATES, 1963-1972



ANNUAL BENEFITS AND COSTS OF IMMUNIZATION AGAINST MEASLES, UNITED STATES, 1963-1972



STATEMENT OF LAURENCE FINBERG, M.D.,* BEFORE THE SUBCOMMITTEE ON HEALTH, LABOR, AND PUBLIC WELFARE COMMITTEE, U.S. SENATE, ON A BILL TO AMEND THE LEAD-BASED PAINT POISONING PREVENTION ACT (S. 1664)

Lead poisoning in children is a disease of the urban environment. At the worst, either death or permanent brain damage may result. The cause of the illness and the means of its prevention are completely known. Nonetheless, screening programs initiated with federal funding detected over 16,000 children with abnormal levels of lead in the blood (>40μg/dl) in the last six months of 1974.[1] This represents 6.5 children for every 100 screened. Thirteen percent of this group were given treatment to reduce their body burden of lead. In this same six-month period 7,791 dwelling units were identified as possessing a lead hazard. The actual numbers here underestimate the total problem because many areas are not being screened. Moreover, if circumstances do not change, such children will keep coming every year.

Lead is a metal which has no known biologic usefulness. It appears in many places in the world and thus finds its way into human beings through the food we eat and the air we breathe. Modern industrial advances have increased the exposure of all of us over that of our ancestors; but for most of us, the increased exposure does not appear to be significant. An important exception is children living in housing that is deteriorating and which possesses painted surfaces either inside or outside which are peeling or crumbling. Children between about one and four years of age place all kinds of things in their mouths and paint chips and crumbled plaster are especially attractive items.

Rather conservative calculations[2] indicate that up to 300μg of lead may be ingested daily by a small child without risk. In houses built and painted prior to the 1940's a single paint chip thumbnail size may contain 300 times this maximum amount (100 mg). Such houses when in poor condition are as unfit for habitation by infants as would a drinking water source contaminated by typhoid bacilli or cholera be unfit to drink. There are, as of 1970, 30 million such houses in use. The bill being considered today provides funds to identify and to rehabilitate (or eliminate) such dwelling units and provides funds to find improved and less costly ways of dealing with such dwellings. Both of these are urgent matters.

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*Professor and Chairman, Department of Pediatrics, Montefiore Hospital & Medical Center of The Albert Einstein College of Medicine.

[1] Morbidity and Mortality. U.S. Department of Health, Education, and Welfare, Center for Disease Control. vol. 24, No. 20, May 17, 1975.

[2] King, B. G.: Maximum Daily Intake of Lead Without Excessive Body Lead-Burden in Children. Amer. J. Dis. Child. 122:337, 1971.

The type of painted surface in the old houses is not the only problem, however. The paints used since 1940 or thereabouts generally have lead in the driers rather than in the pigment but even these may be dangerous when applied in multiple layers and, ultimately, when maintenance ceases, flake off and may be ingested. This leads us to a consideration of how much lead is safe in paint used to paint household surfaces.

If paint contained 0.06 percent lead, ingestion of a 6-layered paint chip with one square inch of exposed surface would provide a dost of 150μg of lead. Assuming that the normal lead intake from usual food, water and air is about 150μg, a child who consumed a mere square inch paint chip containing 0.06 percent lead would be getting his total 300μg with no allowance for lead from any other sources (lead in street dust, etc.). Therefore, if daily intake is to be less than 300μg/day, and if a child with pica (the tendency to eat nonfood substances) can be expected to eat as little as a square inch paint chip daily, the lead content of the paint must be less than 0.06 percent or the child will exceed the daily permissible intake.

New data make the 0.06 percent standard even more urgent as these calculations were based in the assumption that children's absorption of lead from the intestines equals that of adults (5 percent to 10 percent of lead ingested). An April 1973 report by Dr. Barry King now indicates that absorption in young children is closer to 80 percent of the lead intake, meaning that the earlier calculations minimized the harm to children which results from lead paint ingestion.

The problem is further aggravated by newer information, as yet inconclusive, but nonetheless suggestive that levels of lead in children, previously thought to be harmless, in fact are associated with diminished intellectual capacity.[3, 4]

Despite this, the Consumer Product Safety Commission has seen fit to raise the permissible percentage of lead in paint from 0.06 to 0.5 percent. The report announcing this decision based on the judgment on some recent animal experiments in baboons and rats designed to find a safe level of lead ingestion. We believe those experiments to be seriously flawed for the following reasons:

1. The assumption of the size and weight of a paint chip that would be ingested daily by a toddler used by King, by Chisholm, and by experimenters cited is a rather minimal amount, which King and Chisholm understood. The workers using baboons assume it to be a maximal amount which it is not. Thus, a significant number of children would ingest a good deal more in the way of paint chips or painted plaster than they assumed for the purpose of the experiment. Moreover, many children would ingest at an irregular rate, rather than at a slow steady rate, with large, transintestinal gradients and sudden influxes of lead.

2. The age in the animals of the studies reported would not necessarily be comparable for lead absorption as it relates to children. There are new good data showing that absorption of lead from the intestine varies with age. The younger the animal the higher the percent absorption. Thus, for a similar ingestion, children of 18 months–3 years would absorb a higher dose than older persons or comparable animals.

3. The baboon study should have been the most important. The authors completely vitiated any possibility of learning a lower limit of tolerance in their animals by injecting them periodically with iron. There are substantial data from several centers, including some recently obtained by Dr. Joseph Kochen in the Department of Pediatrics at Albert Einstein College of Medicine, indicating that the presence of iron (especially by injection) impressively inhibits the absorption of lead from the intestinal tract. When we extrapolated the data that Dr. Kochen has on rats on a weight basis to the baboons, at least twice as much iron was injected into them as would be needed to bring about this effect. Incidentally, this was also twice as much as was needed to protect against iron loss from the bleeding.

4. The possibility of species difference, as well as age difference, will always plague experiments done on animals for making decisions on human protection. In any such animal program, the data must be looked at in the most cautious and conservative possible light.

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[3] Carson, T. L.: Van Gelder, G. A.: Karas, G. C.: Buck, W. B.: Slowed Learning in Lambs Prenatally Exposed to Lead. Arch. Environ. Health 29:154, 1974.

[4] Perino, J., Ernhart, C. B.: The Relation of Subclinical Lead Level to Cognitive and Sensorimotor Impairment in Black Preschoolers. J. of Learning Disabilities 7:26, 1974.

5. In adapting scanty scientific data to a matter of public policy, a very large safety factor to permit error should be allowed—probably at least one order of magnitude (tenfold). Even if all of the experimenters' assumptions were correct, the commission failed in this most fundamental consideration of providing the kind of protective ratio that is necessary to be reasonably safe.

Thus, we conclude that the position we have taken in the past with regard to a permissible, safe concentration of lead in paint products (0.06 to 0.1 percent) is the only tenable present position. In the future, should evidence be gathered which might warrant liberalization of the proposed standard, we would so recommend. However, at the present time such evidence does not exist. Thus, safety of children should take priority over some inconvenience which may be incurred by paint manufacturers.

Severe lead encephalopathy with a high mortality rate and easily visible morbidity is currently on the decline because slum housing is being abandoned in our inner cities. There are plenty of other housing units, their walls and porches loaded with lead, to serve as hazards when the middle and upper class tenants move and the dwellings are occupied by those who cannot provide or obtain maintenance.

It should be emphasized that if housing built today proves hazardous, the problem will persist for another fifty years. The opportunity is now here to rectify our past unintentional errors with imaginative programs and to prevent further problems at little or no cost by setting appropriate standards. To do less will cause future generations to indict us for gross callousness. After all, our society's most important resource is our children: let us conserve them intact.

Mr. FLORIO [presiding]. Thank you very much.

Dr. Carter.

Mr. CARTER. What is the level of immunization for measles in the United States at the present time? What percentage of children are immunized——

Dr. CARVER. I have the figures here.

Mr. CARTER [continuing]. Against measles?

Dr. CARVER. We have that right here; 65 percent immunized against measles.

Mr. CARTER. Pardon?

Dr. CARVER. Sixty-five percent, sir, of the 1- to 4-year-olds.

Mr. CARTER. Sixty-five percent are immunized?

Dr. CARVER. Against measles.

Mr. CARTER. At a cost of $3 each?

Dr. CARVER. Yes; a cost of $3 each, including vaccine production, administration, and promotion.

Mr. CARTER. And the cost of the number of children who would ordinarily have measles would be approximately $1.5 billion, is that correct?

Dr. CARVER. $1.3 billion would have been the cost of caring for those children who would have had measles and their complications. This was averted during the 10-year period by the use of the vaccine.

In the appendix on the paper by Witte and Axnick, there are some tables.

Mr. CARTER. You give them a live virus, an attenuated live virus?

Dr. CARVER. Yes, sir; attenuated live virus has been very effective. Prior to this vaccine there was a killed virus vaccine but unfortunately, this vaccine led to complications. When a child who received the killed vaccine, either was subsequently exposed to measles or was given the live virus vaccines there were fevers, strange rashes, and other problems, so that the killed measles vaccine is no longer used.

Mr. CARTER. Does the attenuated virus ever give a child a mild case of measles to a subject?

Dr. Carver. Yes, the complications of the live virus vaccine are minimal in that the patient does not have the particular problems with encephalitis. Approximately one-tenth of 1 percent of the children who have natural measles acquire encephalitis but with the live measles vaccine, no immediate encephalitis has been seen and I think that is the major advantage of this.

Mr. Carter. In a sense, it gives a youngster a mild case of measles?

Dr. Carver. A very mild case.

Mr. Carter. And how is he treated for that?

Dr. Carver. The child is allowed to move about because he is neither ill nor contagious.

Mr. Carter. Do you ever use immune globulants in a case?

Dr. Carver. The early vaccines were given with gamma globin at another site. The early vaccines were less attenuated than the current vaccines, thus, the Edmonson B. vaccine was injected into one arm and a measured amount of gamma globin was injected into the other arm. Subsequent to that, by serial passage of the strain of measles in the laboratory they have further attenuated the virus and gamma globin is not given along with the vaccine at this time.

Mr. Carter. Yes, sir; but it has been very successful, has it not?

Dr. Carver. Remarkably successful. The only problem is that one would not give this live vaccine to a patient whose immunization is suppressed. It should not be given to a patient with a malignancy since those patients could get into difficulcy with this.

Mr. Carter. Which patients?

Dr. Carver. Patients with malignancy or other form of immune suppression. But the normal patient tolerates this very well and it has effectively eliminated measles from the immunized population.

Mr. Carter. We did have 4 million cases, I believe you stated here?

Dr. Carver. Yes.

Mr. Carter. What is the rate, what is the number per year now?

Dr. Carver. The estimates for 1975 are that we will have 20,000 cases and that we should have about 20 to 25 deaths this year.

Mr. Carter. What happens to the fetus of a pregnant woman when she has rubella?

Dr. Carver. With rubella the fetus of the pregnant woman, if the rubella occurs during the first trimester, and particularly the first 8 weeks, will be malformed in many cases. One will get a child with neurologic abnormalities so that the child later on will have a small brain and retardation, cataracts, deafness, poor growth, congenital heart disease, and this, of course, is a fantastic tragedy.

Mr. Carter. And hernias sometimes?

Dr. Carver. Yes, sir, and the extended rubella syndrome in 1964 showed also they could have enlargement of the liver and spleen, jaundice, and thrombocylopenia.

Mr. Carter. Did you ever deliver an anencephalic?

Dr. Carver. With this situation?

Mr. Carter. Yes.

Dr. Carver. No, I have not seen a complete anencephaly but there is marked microcephaly.

Mr. Carter. I have. Are there any particularly low immunizations at the present time for single diseases?

Dr. CARVER. No, I think as we look at the tables across the board, again it seems to be particularly low among the indigent inner-city population and particularly among the nonwhite population. Also, the indigent rural population has a low incidence of immunization, hence, the polio outbreaks in Texas among that population.

Mr. CARTER. Yes, sir. It seems to me that we should have a better system of seeing that immunizations are carried to all youngsters.

Dr. CARVER. Yes; I am strongly in agreement with you, as is the Academy, and one of our concerns is that with this bill and with the provisions for motivating parents, one hopes that one will be able to achieve better immunization throughout the entire socioeconomic spectrum.

Mr. CARTER. As a pediatrician, when do you give DTP?

Dr. CARVER. The first dose is given 2 months, the next dose 4 months, and the third 6 months, and a booster at 18 months and another booster at 4 to 6 years.

Mr. CARTER. Sometimes it is given much earlier than that?

Dr. CARVER. This is the schedule that we on the Red Book Committee have advised and this, of course, is given along with the polio immunization and thus, this allows two immunizations to be given at the same time. With the polio immunization we want to have at least 8 weeks between immunizing swallows of this because it is a live vaccine and if for any reason one of the three types takes over we want to allow a sufficient period of time for the replication of that type to stop so that it does not interfere with the replication of the other two types or the subsequent dosage swallow.

Mr. CARTER. How do you account for the outbreak of whooping cough in Maryland last year—pertussis?

Dr. CARVER. I think there are two possibilities. DTP with the pertussis component, has been quite successful throughout the United States in cutting down on pertussis and, of course, if one is in a nonimmunized population, one can get pertussis.

Mr. CARTER. The level of immunization was not high enough?

Dr. CARVER. I would think this would be the major aspect. The other aspect which I would mention, some of the patients with the classic pertussis syndrome, as you know, can have this due to an adenoviral infection which may be acting in concert with the pertussis organism or perhaps by itself. So a small percentage of the cases may be due to adenovirus infection.

Mr. CARTER. It would not have been pertussis at all?

Dr. CARVER. Exactly; it would be the pertussis syndrome.

Mr. CARTER. All right. What is your feeling about the issue of categorical funding of the lead-paint poison program?

Dr. CARVER. Dr. Finberg has given testimony to the Senate on this and that we have amended and I believe Dr. Curran, who follows me in testimony, will discuss this specifically. But it would seem appropriate that categorical funding be provided for each of these separate items to prevent a competition for funds in one large category.

Mr. CARTER. Do you have many cases, your Johns Hopkins, of lead poisoning?

Dr. CARVER. Yes; we still see this because our hospital is located in an inner city area where the homes of the people still have lead paint and the young children chew on this, particularly at the window sill level, and this is still a problem.

One of the experts in the area is at Johns Hopkins, Dr. Chisholm.

Mr. **Carter.** About how many cases did you see last year or the year before?

Dr. **Carver.** We personally at Hopkins probably see about 10 or 15 cases a year.

Mr. **Carter.** How many cases do you estimate occur in the State of Maryland?

Dr. **Carver.** I would leave this to Dr. Curran to talk about the incidence.

Mr. **Carter.** Do you have any statistics on the incidence of lead-paint poisoning in New York City as compared with instances just before the program began?

Dr. **Carver.** Again, I think that Dr. Curran is from New York City and is involved with the lead-based paint program and I would prefer that she answer that.

Mr. **Carter.** Well, thank you very kindly for an excellent statement.

Mr. **Florio.** Mr. Preyer.

Mr. **Preyer.** Thank you, Dr. Carver, for a very interesting statement, a very helpful one.

What approaches can you suggest on this subject for providing immunization to indigent people who currently are not being served by our health system?

Dr. **Carver.** I think a number of approaches can be used. One would be a neighborhood saturation approach, concentrating on the neighborhoods involved. Day care centers would be appropriate areas to go into because optimally we immunize with most of these agents within the first year of life and the current programs mandating immunization as a precondition for school attendance would not provide immunization until 5 or 6 years of age. I also think that the health care center comprehensive care programs should be emphasized. A good deal of this would involve not only providing the vaccine funds but also providing funds for motivating the parents through various public relations approaches to seek the immunization.

Just providing the funds for the vaccination will not be sufficient, as we have seen in the past.

Mr. **Preyer.** On the point of lead-paint poisoning, should we define lead paint and, if so, how should we define it?

Dr. **Carver.** Again, I would leave the lead paint aspect of this to Dr. Curran, who is an expert in this area. My area of expertise is in infectious diseases.

Mr. **Preyer.** All right, sir, than you very much.

Mr. **Florio.** Mr. Hastings.

Mr. **Hastings.** I thank you, Mr. Chairman.

Dr. Carver, I am sorry I was not here to hear your entire statement. I tried briefly to read through it.

I am extremely interested in the many references you make in your statement—I might say particularly as they concern a broad subject of questions becoming so very important as it relates to increased costs, and the economic impact, of course, of a $118 million health care system that we are dealing with today.

Where do you think, mainly, we are falling down as far as the Federal role relates to the immunization programs?

Dr. CARVER. I think it is extremely important that the Federal Government assume a primary role for making funds available specifically for immunization.

Mr. HASTINGS. But is funding the most important consideration?

Dr. CARVER. I think this would be the first consideration because, certainly, our experience when this has been left to the States, has been to show that the States do not all, individually, do this. One example is that between 1968 and 1971, categorial funds were not available for measles and measles immunization programs lagged and the incidence of measles increased threefold in the United States during this period.

In addition to this, I think that the Federal Government has to, through CDC, take a primary role in motivating people to use vaccines, particularly the indigents, but also the middle class.

This Idaho study which was published in the October issue of Pediatrics, points out that patients of private physicians by the age of 2 had not been adequately immunized, in many cases.

Mr. HASTINGS. I draw an inference from what you are suggesting that if the Federal Government should go to the bloc grant approach to States, saying to the States: "You have the knowledge and the ability, here is the money; now, go ahead and do it within the framework of what you think is most important in delivery health," perhaps the States would choose to downgrade immunization programs?

Dr. CARVER. Yes; I would think that the money provided the States should be specifically targeted for immunization and that also the expertise of the people at CDC be used to bolster the vaccine programs in the States.

I do not believe that this can be left to the States with unallocated funds.

Mr. HASTINGS. I am sorry to hear that. I suspect what you are saying is true.

Dr. CARVER. I think our experience in the past shows that this is true.

Mr. HASTINGS. I do not disagree with you at all.

Thank you very much, doctor.

Mr. HEFNER. I would like to apologize for not being here for all your statement.

I would like to ask a question. Please make any comment you would like in any depth you would like.

In your opinion, what kind of job is HEW doing on these programs that you have been discussing?

Dr. CARVER. I think that they are doing a good job within the constrictions of the funding available. I think with adequate funding, a much better job could be done. I know that the people at CDC would do a very good job if specific funds were allocated so they could get the programs moving. CDC people have come up with a plan, partially in response to an address by the chairman of this committee, Mr. Rogers, to the Academy of Pediatrics for an attempt at eradication of measles with increased level of immunization plus what they call outbreak control forming a barrier of immunized people around any outbreak to try to prevent the spread of this—analogous to the smallpox eradication program going on in other parts of the world.

They certainly have the expertise to do this, but without sufficient funds they certainly cannot do this. If funds were decreased, as suggested by the administration, this would be disastrous with respect to the immunization program.

Mr. Hefner. H.R. 8278 contains two titles.

Dr. Carver. Yes.

Mr. Hefner. I wonder if you would like to make any comment about title I.

Dr. Carver. The first title with respect to the education? I think this is very important. I am not sure that a separate institute of the National Institutes of Health is needed for health education, but certainly health prevention at this point makes a good deal of sense.

As I mentioned in my testimony, we are at a stage now where we have the methodology to prevent disease in the infectious disease area. Unlike the cancer and heart disease program where a good deal of basic science research is needed to achieve such methodology, our problem is the application of this. And certainly, public education is needed in this area and also in other areas, appropriate use of diet, getting people to stop smoking. All of these things need public education, and certainly a real emphasis is needed in this area.

Mr. Hefner. You referred to stopping smoking. Do you think we need a stronger approach this way?

Dr. Carver. Yes; I certainly think that a strong educational approach is needed so that people avail themselves of what we now have available with respect to preventive medicine. Certainly, on a cost-benefit ratio basis, preventive medicine makes a great deal of sense, as the figures I have quoted point out.

Mr. Hefner. You feel that technology along with the education of people, should be available to know how to use the technology?

Dr. Carver. That is right.

Mr. Hefner. One is as equally important as the other. Without the technology, there is no point in having——

Dr. Carver. Exactly—and without the education, people will not use the technology, and I think we have to make specific funds available for the education, and we have to be innovative in this area. I think that this is an entirely new approach, and that members of this committee and members of the various Academy of Pediatrics committees have to work together to evolve the best way of motivating the people involved.

Mr. Hefner. Thank you, sir.

Mr. Hastings. Just one observation about our concern, and it somewhat follows what you are suggesting.

The figures I have made available to me show since 1950, about 25 years ago, in this country, when we were spending $26 billion a year on delivery of health in this country, to this year, when I reiterate what I said, we are spending $118 billion, we have a mortality rate that has hardly changed at all. If anybody should be aware of what you are saying, as it relates to preventive medicine and education, as the gentleman from North Carolina points out, it is time that not only this Congress, of course, but the entire health care system, and certainly including the professionals like yourself, have a full recognition of the many changes that must be accomplished within the framework of this delivery system if we are going to change those very things that have been goals to us for years. But it concerns me greatly that mortality rates in 25 years have changed very, very little with that huge increase in the percentage of our gross national product devoted to the delivery of health care.

Dr. CARVER. I would certainly agree with you and that I think we have to move from a crisis-oriented approach to a preventive approach, which is far more efficient.

Mr. HASTINGS. But do not expect the Congress to do it all because we do not get the lead from the professionals in the field of health care delivery. Without the changes perhaps in the economic structure of the system so that we have certain incentives moving toward delivery of good health and prevention, do not just expect the Congress to wrestle, for example, with the bankrupt railroad situation in this country because the free enterprise system has made a failure of it. It is an unimaginable problem dumped in the laps of Congress to say OK, you solve it; and in health, I might suggest to you we are going to have to have that kind of change in direction from the components of the delivery system itself and not just depend upon us, we in Congress, to make those kinds of changes.

Dr. CARVER. I certainly agree with you, and here again, the Academy of Pediatrics is oriented in the direction of preventive medicine. I think you will find the members of the academy most eager to cooperate with you in this respect.

Mr. HASTINGS. I am sure you will have the opportunity to offer that kind of assistance to us in the future. We will ask for it. Thank you.

Mr. FLORIO. First of all, I think it is appropriate for the committee to compliment the Academy for having been in the forefront and showing the lead to people throughout industry as well as Government with regard to the need for prevention and taking care of people before they get sick rather than waiting until they get sick.

You made the comment advocating wide-scale immunization and then you seemed to be advocating also this outbreak.

Are they incompatible?

Dr. CARVER. No; I actually raised this question with the people who came up with the program yesterday discussing it with them. I think the two approaches can go on simultaneously. It is very important that wide-scale mass immunizations progress hopefully to reach 100 percent of the susceptibles but during that period whenever an outbreak does occur that a particular program be then concentrated in this area.

One may not be able to prevent measles in the primary contact but could at least by getting immunization into the area, into the susceptibles, prevent it among potential secondary and teritary contact and hence, contain the epidemic. This approach has been tried once in Chicago and CDC people feel it has been successful. But this in no way should prevent a conflict situation. I feel quite strongly that the basic approach is that of achieving wide-scale immunization on a forward-looking basis and not waiting for the crisis.

Mr. FLORIO. I am not sure if you were here yesterday when HEW came, and I thought that it was fairly clear they were advocating an alternative to the total immunization, which was the crisis control situation.

Dr. **Carver.** This concerned me also. I have obtained a copy of this plan and if the members of the committee would like this I have an extra copy to submit.

After reading this plan I discussed this with the people at CDC who are responsible for administering the outbreak control aspect and they assured me that this was an additional aspect of the control but not an alternative, and I would feel very strongly that if the members of the Department of Health advocated this as an alternative that they were wrong. Both programs should proceed simultaneously and the staff at CDC with responsibility for these programs, agrees with us.

Mr. **Florio.** You make reference to a law case in your statement and its potential adverse effect upon the immunization program.

Could you briefly tell us what the case is?

Dr. **Carver.** Are you acquainted with the *Wyeth* v. *Reyes* case?

Mr. **Florio.** No.

Dr. **Carver.** An outbreak of poliomyelitis occurred in Texas. Because of the outbreak immunization was brought into the area to protect children in the area. One of the children who had been immunized developed paralysis and subsequently the parents sued the Wyeth Co. who had produced the vaccine used.

Now, this case creates a number of concerns for us. The first concern is that the findings of the court were totally contradictory to scientific fact. The strains of virus isolated from the child by markers, which are available, were shown not to be the vaccine strain but the wild strain, hence, this child was paralyzed not because of vaccination but because he had acquired natural polio during the outbreak.

This fact was made clear to the court. The Academy submitted an amicus curiae brief. Nevertheless, the jury found for the parents against the company involved and apparently, a finding of fact cannot be reversed by a higher court and the Supreme Court decided not to hear the case.

The second problem that this case raises is that in his decision Judge Wisdom of the circuit court stated that when an adverse effect occurs with a vaccine that the loss ought to lie not where it falls on the victim, which certainly we agree with, but should be borne by the manufacturer as a foreseeable cost of doing business and passed on to the public in the form of price increases to the customers.

I think there is a real problem with this concept. (1) It has a connotation that there is an implication of malpractice on the part of the manufacturer. If indeed the manufacturer produces a vaccine that meets the requirements of the Federal Government and is safe as a vaccine can be, one can question whether then a judgment of this malpractice type should be placed against him.

Another problem is that this particular judgment has, according to information we received at our last meeting at the Academy, created some concern among the manufacturers of vaccines and some of whom who have raised the question as to whether they wish to remain in this business because of the economic risks.

One thought in this respect that we have had and certainly would like to discuss with the Congress is as to whether it would be appropriate in the United States to have legislation comparable to legislation which exists in Denmark, Germany, and Japan, where indemnification occurs analogous to workman's compensation in these rare cases where an adverse outcome occurs with immunization. This would seem to be perhaps the most just method of handling this particular problem.

A third problem that comes up with the *Reyes* case again is Judge Wisdom's finding that in the case of a prescription drug which is unavoidably unsafe and as to which there is a certain, though small risk throughout the population, there must be either a warning, full, meaningful, and complete, so as to be understood by recipient or individualized medical judgment that this treatment or medication is necessary and desirable for the patient.

Well, as we have discussed in the preceding testimony, it is clear that these vaccines are desirable for the patient. The problem of informed consent arises and there has been concern expressed by health departments as to what will constitute informed consent under this situation and as to whether mass immunization programs would be hindered by people being frightened during the signing of forms. Also, what is truly informed consent if one is dealing with an unsophisticated person, even if they sign a form, do they truly understand the risks involved?

There again, I think this is an issue which might be appropriate for members of this committee to consider.

Mr. **Florio**. Well, without going into too much detail with the merits of the case, I suppose what the courts have done, sometimes wisely and sometimes unwisely, is review the totality of the facts and specific circumstances to which someone does consent. Perhaps I would be more inclined to support that approach even if tolerating an occasional decision that may not be as wise, even if it comes from a Judge Wisdom, in lieu of legislatively spelled out language which may be not appropriately flexible enough.

I would like to for the record, clarify what I think you have indicated, that you feel it would be appropriate to have a categorical approach to each of these areas as opposed to the business approach, which is to lump five or six areas together.

Dr. **Carver**. Yes.

Mr. **Florio**. I think it goes without saying also, you would not support the proposal of HEW to reduce the total cumulative appropriation from $54 million down to $35 million. Is that appropriate?

Dr. **Carver**. Yes.

Mr. **Florio**. You feel that reduction would have an adverse effect upon the substantive programs affected?

Dr. **Carver**. Definitely; I think that reduction would lead to totally inadequate funding for the specific programs involved.

Mr. **Florio**. You seem to be concerned about the inherent competition that would take place from this massing.

Dr. **Carver**. Yes; if the funds are massed in a central fund, particularly if the central fund is inadequate, I think there would be by necessity, a competitive aspect between a number of very needed programs.

Mr. **Florio**. And the last point I would like to raise is, perhaps, if you do not mind, to utilize your expertise—are you familiar with the mass PKU screening programs available in States, particularly in New York State?

Dr. **Carver**. Somewhat.

Mr. FLORIO. What is your opinion as to the success and desirability of such programs?

Dr. CARVER. If a child with PKU is detected early, one by special diet can avoid the situation where the child becomes retarded and, therefore, this makes a good deal of sense.

Mr. FLORIO. It is my understanding that the same screening tests will also uncover things such as urine disease and four or five other things.

Dr. CARVER. There are a number of screening tests available and they again would be desirable, even though the incidence of these diseases is relatively small. Any parents who have a single child with this, of course, consider this quite important.

Mr. FLORIO. Is it a complicated process?

Dr. CARVER. No.

Mr. FLORIO. Or costly process?

Dr. CARVER. No; I cannot give you the exact costs but it is quite inexpensive.

Mr. FLORIO. I believe it is 66 cents?

Dr. CARVER. It under a dollar.

Mr. FLORIO. Do you think there would be any desirability in having a demonstration project provision included in the bill to provide incentive to States that have not undertaken such a screening process to become involved in initiating such screening?

Dr. CARVER. I think this would be useful.

Mr. FLORIO. Thank you very much. I have no further questions.

Thank you very much. We appreciate your testimony.

Dr. Anita Curran.

STATEMENT OF ANITA S. CURRAN, M.D., M.P.H., DIRECTOR, BUREAU OF LEAD POISONING CONTROL, NEW YORK CITY DEPARTMENT OF HEALTH, ON BEHALF OF URBAN ENVIRONMENT CONFERENCE

Dr. CURRAN. Mr. Chairman and members of the Subcommittee on Health and the Environment, I welcome this opportunity to present to you my experience with the problem of lead poisoning and to urge that lead-paint poisoning prevention be removed from title II of H.R. 8278 and be addressed in a separate title of the bill.

I am Anita Stiles Curran, director of the Bureau of Lead Poisoning Control in the Department of Health of the city of New York and clinical assistant professor of pediatrics, New York Medical College. As director of the Bureau of Lead Poisoning Control, I am responsible for the screening for lead poisoning of all at risk children between the ages of 1 and 6 in the city of New York, and for monitoring the medical management and followup of all confirmed positive children. We are currently screening approximately 100,000 children per year and monitoring the management and followup of an additional 30,000.

Over the past 12 years I have served in various capacities as pediatrician and public health physician in New Jersey and New York. As medical coordinator of the Newark, N.J., Preschool Council and well child physician with the Paterson, N.J., Department of Health, I became increasingly concerned about the health problems of the urban preschool child. In order to better equip myself to deal with these problems, I obtained a masters degree in public health from Columbia University School of Public Health.

I have been employed by the New York City Department of Health since November 1973, first as assistant director of the Bureau for Handicapped Children, and now as director of the Bureau of Lead Poisoning Control.

I would first like to give you a brief overview of the problem of lead poisoning, and then discuss some specifics.

Lead has been mined and worked by men for thousands of years. It is versatile, malleable and virtually indestructible. It is one of the most useful of metals. The inappropriate use of lead, however, has resulted in outbreaks of lead poisoning in humans from time to time since antiquity.

The disease, sometimes called "plumbism" (from the Latin word for lead) was first described by the Greek poet-physician Nicander more than 2,000 years ago. Some historians facetiously blame the fall of the Roman Empire on the fact that the Romans used improperly glazed pottery jars to store their wine. The acid in the wine leached the lead from the glaze and may have caused cases of unsuspected chronic lead poisoning.

Today our concerns about the dissemination of lead into the environment are twofold:

One: There is a need to know whether or not the current level of lead absorption in the general population presents some subtle risk to health.

Two: There is an even more urgent need to control this hazard in several well-defined groups that are known to be directly at risk: young children who live in dilapidated housing where they can nibble chips of leaded paint, whiskey drinkers who consume quantities of lead-contaminated moonshine, people who eat or drink from improperly lead-glazed earthenware, and workers in certain small-scale industries where exposure to lead is not controlled. Of these the most distressing is the large group of children between 1 and 6 years of age who live in deteriorating buildings and have the habit of eating nonfood substances, including peeling paint, containing lead. In the young, preschool child of the urban ghetto, lead poisoning can be a major source of brain damage, mental deficiency and serious behavior problems.

Lead is not a trace element essential to nutrition. However, traces of lead are everywhere, and minute amounts are found in normal diets. In adults the average dietary intake is estimated to be about 300 micrograms per day (a microgram is one millionth of a gram), with 90 percent excreted unchanged. The 10 percent that is absorbed is excreted by the liver and kidneys. We breath in an additional 5–50 micrograms per day. Under normal circumstances this, too, is excreted and there is no net retention of lead in the body.

However, once the total daily intake rises above 1,000 microgram, signs of toxicity begin to occur. The allowable level in children is much lower, only 300 micrograms per day. Studies by Tepper[1] and Kehoe[2] estimate the average child's intake of lead from food, water and air to be 106 to 146 micrograms per day in Tepper's studies, and 150 to 200 micograms per day in Kehoe's older studies. Using these estimates. a child may consume an additional 100 ug to 150 ug a day before undue absorption occurs with resultant excess body lead burden. Add to this the knowledge that a chip of paint about the size of an adult's thumbnail can contain between 50 and 100,000 micrograms of lead and you can see that a child eating a few small chips a day easily injects hundreds of times the allowable limit.

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[1] Tepper, L. B.: Statement before the DPI ad hoc committee meeting, Cincinnati, Ohio, 1971.

[2] Kehoe, R. A.: Harben Lectures, J. Royal Institute Public Health, 24:81–97, 101, 129–143, 177–203, 1961.

Childhood lead poisoning in the United States is seen most frequently in children of pre school age who live in deteriorated housing built before 1940 (when titanium dioxide began to replace lead in the pigment of most interior paints). According to Chisolm[3] the causative factors are commonly a triad: a dilapidated old house, a toddler with pica and parents with inadequate resources to cope with the family's needs.

Pica comes from the Latin word for magpie a bird of allegedly voracious and indiscriminate appetite. Today the term pica denotes the habitual, purposeful and compulsive search for and ingestion of, such non-food substances as clay, plaster, laundry starch, string, putty, paint chips, paper, dirt, crayons, cigarette butts, yarn and matches. The incidence of pica in the general population seems to increase during times of stress. Women (especially pregnant women) and young children are most vulnerable.

Lead intoxication results from chronic increased ingestion of lead. Prolonged ingestion is much more damaging than a single large ingestion, as inorganic lead is poorly absorbed, and much of a single dose passes unchanged through the intestinal track. However, with prolonged ingestion, small amounts of retained lead are stored, largely in the bones, and an excessive body burden of lead builds up and is only very slowly excreted. It takes at least twice as long to excrete the excessive lead as it does to accumulate it. For example, if a child with pica ingests lead over a 2-year period (from 1 to 3 years of age) it will require at least 4 years (or until age 7) to excrete the lead by normal physiologic mechanisms.

The repeated ingestion of leaded paint-chips for about 3 months or longer can lead to clinical symptoms of lead poisoning and eventually to the absorption of a potentially lethal body burden of lead. Pica tends to persist until 3–5 years of age. In the brain damaged child, the habit may persist longer.

Long-term lead ingestion is accompanied by recurrent acute toxic episodes of symptomatic plumbism. For reasons not fully apparent, 80 percent or more of these episodes occur during the summer months. Clinical manifestations tend to vary with both the age of the child and the amount of lead ingested. They vary from convulsions and encephalopathy (edema of the brain) to vague, nonspecific complaints such as nausea, abdominal cramps, vomiting, decreased interest in play, or conversely, hyperactivity and behavior disorders, et cetera. Encephalopathy is most common in the child 15 to 30 months of age. Before chelating agents were available about two-thirds of all children with lead encephalopathy died. Now the mortality is less than 5 percent. However, 25 percent of the children who survive the first episode will have permanent brain damage. If the child has repeated episodes, the risk rises to virtually 100 percent.

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[3] Chisolm, J. Julian, Jr.: Lead Poisoning, Scientific American, vol. 224, No. 2, pp. 15–23, February 1971.

Although I will discuss New York City in detail, as that is the area with which I am most acquainted, the facts will apply equally well to any of a large number of cities. The difference is mainly one of magnitude. There is no doubt that childhood lead poisoning is a real problem in many of our older urban areas and in some rural communities as well. The suburbs have escaped to a large degree because of the relative newness of their housing units.

Around the turn of the century, and for a number of years thereafter, homes in the south Bronx, north Manhattan and central Brooklyn were among the finest in the city. These houses were occupied by middle and upper class families who took great pride in their homes, and who used high quality lead paint at frequent intervals to maintain them. Over the years, the profile of the city has changed. These once proud areas have become the city's worst slums. The houses are decaying, crumbling and abandoned. The plaster crumbles; the paint, consisting of many layers with high lead content, chips and peels, and is accessible to small children. Surveys indicate that there are at least 400,000 such apartment units in the city.

These homes are now occupied by the city's poor. Most of these families do not have the resources required to repair their apartments or to protect their children from what is, all too often, a hazard unknown to them. In many cases, the landlord is unwilling or unable to make the necessary repairs.

Using the 1970 census figures, it is estimated that there are approximately 650,000 children between the ages of 1 and 6 living in the city of New York. Roughly 280,000 of them occupy the dwelling units described above. These are our children at risk, our target population; 90 percent are black or hispanic.

Although leaded paint presents the greatest hazard to these children, other sources of the metal must also be considered. In recent years, there has been growing concern with the effect of auto emissions. New York City is a high traffic density area, one of the highest in the Nation. Our children live and play only a few yards away from major arteries, truck routes and idling cars and taxicabs.

At present, it is impossible to estimate how much this contributes to the child's body burden of lead.

The center for disease control in Atlanta, Ga.[1] recently defined undue or increased lead absorption as existing when a child has a confirmed blood lead level of 30–79 micrograms per 100 milliliters of whole blood or, an erythrocyte porphyrin (E.P.) level of 60–189 micrograms per 100 milliliter except where the elevated E.P. level is caused by iron deficiency. An elevated erythrocyte porphyrin is a sign of metabolic toxicity, of the body's failure to produce hemoglobin, the oxygen containing pigment in red blood cells. It is elevated in lead poisoning and to a lesser degree in iron deficiency anemia. Frank lead poisoning exists when a child has a confirmed blood lead of 80 micrograms or greater per 100 milliliters of whole blood, with or without symptoms, or an E.P. level equal to or greater than 190 micrograms per 100 milliliters, with or without symptoms. All symptomatic children with other laboratory signs of increased lead absorption must also be considered as lead poisoned.

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[1] Center for disease control: Increased lead absorption and lead poisoning in young children. U.S. Department of Health, Education, and Welfare. Public Health Service. March 1975.

Using the above definitions, 54,305 children were screened so far this year in New York City, with 4,827 falling into class II, low increased lead absorption, low to moderate risk; 846, class III, high absorption, high risk; and 186 with unequivocal lead poisoning in need of emergency treatment. Approximately 200 children have been hospitalized. In addition, 2,129 children were identified as requiring a workup for iron deficiency anemia. This is possible because of the way we conduct our screening program. If the E.P. is positive, then we go ahead and do the microlead. So, what we have done there, we have identified the children who are either iron deficient or who have lead poisoning, then by using the blood lead test, we separate out the children who have lead poisoning from the ones who most likely have some degree of iron deficiency anemia. Thus, we are able to do both with one screening technique.

In all, 7,985 children were earmarked as needing further evaluation and/or medical management and followup. This is an erythrocyte porphyrin positivity rate of 14.7 percent. If this percentage is applied to the total population of at-risk children, this results in an estimated 41,187 children with some degree of excess body burden of lead, and/or some degree of iron deficiency anemia; 30,240 would be considered cases with some degree of lead intoxication by CDC definition. Even if we can maintain our current rate of screening, we will be able to screen only one-third of the at-risk children per year.

Over the years since its inception in 1970, our program has had a decided impact on the lead poisoning problem in the city of New York in that the numbers of children with unequivocal lead poisoning and extremely high blood levels of lead have dropped steadily. This is due to vigorous screening in high risk areas and an increased awareness in the population at risk because of our educational programs. We are reaching the children earlier and are able to intervene before symptoms and overt brain damage occur. However, we have not been able to reduce the numbers of children exposed to lead hazards or those who have low increased lead absorption, as hazard abatement has always been poorly funded and a weak aspect of all lead poisoning legislation.

The time has come when we must face the fact that even our asymptomatic children are being damaged. An increasing volume of evidence appears to indict chronic, subclinical, tissue levels of lead as one of the many causes of learning disabilities and behavior disorders.[1] [2] Levels as low as 25 micrograms have been cited by some investigators as causing hyperactivity. Hazard abatement and housing repair must become an integral part of the treatment of lead-poisoned children.

The New York City program uses a cutoff point of 40 micrograms for our mandated housing repair. This is necessitated by the magnitude of our problem and the constraints of our limited resources. Since January 1, 1975, 1,366 children have been identified as having 40 micrograms or higher blood lead. Also, 1,337 homes have been inspected, with 849 (63.5 percent) found positive. The lead hazard has been reduced in 466 of these homes to date. The landlord was responsible for repairing only 25 percent, the remainder being repaired by the emergency repair program of the Housing and Development Administration.

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[1] David, Oliver, et al.: "Lead and Hyperactivity," the Lancet, pp. 900–903, Oct. 28, 1972.

[2] Perino, Jan & Ernhart, C.: "The Relations of Subclinical Lead Level to Cognitive and Sensorimotor Impairment in Black Preschoolers," Journal of Learning Disabilities, December 1974.

All the cases identified as 40 μg or above in February and June were examined to determine the success rate in finding possible sources of lead exposure. The results are as follows:

1975—February: Source found in original apartment, 73; source found in supplemental apartment, 4; source found in both, 6; no source found, 13; no investigation possible, 6; total 102.

June: Source found in original apartment, 74; source found in supplemental apartment, 1; source found in both, 10; no source found, 26; no investigation possible, 10; total, 121.

Totals: Source found in original apartment, 147; source found in supplemental apartment, 5; source found in both, 16; no source found, 39; no investment possible, 16; total, 223.

In summary, for the 223 cases in these 2 months, there were 207 (93 percent) successful investigations of the child's environment. For those 207 cases, possible lead sources were found in 168 for a percentage of 81.2 percent (source found in original apartment, 145; supplemental apartment, 5; both original and supplemental, 16). In 39 cases out of 207 (18.8 percent), no source of lead was found after thorough investigation.

I now find myself in the strange position of recommending a concept that I am basically opposed to, that of categorical programs. As a pediatrician, I have been trained to consider the whole child, not as an illness or as an appendix, or as a statistic, but as a complex human being whose well-being is affected by socioeconomic, educational, and ethnic factors, as well as genetic endowment and a variety of health factors. In fact, by every aspect of daily living. In the ideal world of unlimited resources, the prevention of illness and the preservation of health should be an all-inclusive activity involving education, housing, nutrition, medical care, et cetera.

Unfortunately, in the real world, such a utopia does not exist. Americans have been taught for generations to think in categories. There are programs to combat cancer, hypertension, muscular dystrophy, cerebral palsy, et cetera. There are drives to collect funds for the March of Dimes, the United Fund, and other worthy causes. Often it is the program that makes the most noise or collects the largest constituency that gets the most money. In this respect, lead poisoning is way down the list. It is not a popular disease. It is a silent enemy. If a child is unfortunate enough to develop paralytic polio, it is at once apparent to all who see him; a child with measles has a high fever, red, watery eyes, a persistent cough, and is obviously a seriously ill child. Lead poisoning is subtle. To the casual observer, the child may seem completely well. Obvious signs and symptoms are infrequent, and often develop when it is too late to prevent permanent brain damage, or even death.

Worse yet, lead poisoning is not a middle-class disease. Although no one is immune, it most frequently affects our poorest, least-educated families. At any one time, it is estimated that over 30,000 children in the city of New York alone carry an excess body burden of lead. Just picture in your mind what the situation would be like if 30,000 New York City children had polio, or measles, or muscular dystrophy. And in a sense, lead poisoning is contagious. The child "catches" the disease from a contaminated house rather than from an infected child. And more importantly, the house serves as a carrier of the disease, transmitting it from child to child.

No child should ever have lead poisoning. It is not only a treatable, but a completely preventable, disease. No child should ever be exposed to harmful amounts of lead. The public health aspects of lead poisoning have been known for many years. But unless health professionals speak out in defense of continued specific funding, lead poisoning programs will succumb to the more vocal pressure groups advocating programs for more visible, but not necessarily more serious or more common, health problems. Thank you.

Mr. FLORIO. Thank you very much for a very informative statement.

Mr. Preyer.

Mr. PREYER. Thank you. I want to join the chairman in saying this is a remarkably clear statement to people like me who have not really understood lead poisoning other than at the headline level. It is a very interesting statement.

I gather that all paints since 1940 do not contain lead?

Dr. CURRAN. No; in 1940, they began using titanium dioxide to a larger degree. I think they needed lead for the war effort, or something along those lines. It has only been since 1959, I believe, either 1956 or 1959, that it has been illegal to have lead in paint. So that in that period, between 1940 and 1959, there was a gradual decrease, but up until that time there was still paint being manufactured with lead.

Mr. PREYER. So buildings up until 1959 would at least be at risk on this?

Dr. CURRAN. Yes.

Mr. PREYER. I was interested to learn about pica. Apparently that is a recognizable disease, the word for the magpie.

Dr. CURRAN. Sign.

Mr. PREYER. Can you spot that in children?

Dr. CURRAN. Yes; you can. Not, for instance, the physician examining the child, looking at the child, no; but a parent or guardian or someone spending a considerable time with the child will notice that anything and everything goes into his mouth to the degree that is beyond what you would normally expect. Every child mouths—they mouth their toys, they put their fingers in their mouth, but these children actually search out and look for little objects to eat. Many times it becomes extremely selective. You will see a child who will pick and pick up and roll up the fuzz from his blanket, and that is all he will eat; or you will see another child who will pick at paint chips or newspaper. Many times it becomes extremely selective, and many times it is very compulsive to the extent that you will really have to eliminate that from the child's environment to stop him from eating it.

Mr. PREYER. This is something, I gather, that does not ordinarily persist beyond the age of 5?

Dr. CURRAN. It usually does not persist much beyond school age, no.

Mr. PREYER. So most of your children at risk are very young?

Dr. CURRAN. Yes; that is correct. But it can carry over. In other words, a child with extremely high lead burden when he is 5 or 6 may continue to have elevated levels until 7, 8, or 9, depending on the length of time it takes him to excrete all that stored lead.

Mr. **Preyer.** I will ask you the question I ask the wrong expert before: should we define lead paint and how should we define it?

Dr. **Curran.** All right. I think you really have to look at this in two separate ways. One is a hazard of leaded paint that already exists in the home, and the other is what should we consider a hazard for children of the future.

I think the definition that we have in the city of New York for our hazard abatement now, which is 0.5, or half a percent, on the walls now, is reasonable from the point of view of talking about current hazards. We are talking about layers of paint that have built up over 20, 30, 40 years. There may be 8, 9, 10, 15, 16 layers of paint, and what we are talking about when we take a chip is this entire chip, composed of many layers, having a percentage of 0.5 percent. That is one aspect of it.

The other aspect of it is, what about 20 or 30 years from now? We are talking about new paints going on the wall. I have some figures with me to outline the amount of lead in each individual layer of paint depending on the percentage. This was done by Barry King, Ph. D., in Cincinnati. I think it is quite informative, and if you are interested, I have copies that I can leave with you, indicating that if you are going from a percentage of 0.5 percent, which is what we have as our limit now in New York City, it takes one layer, a chip the size of one centimeter square, to provide two-thirds of the daily allowable limit; and if you remember, when Tepper did his study, he indicated a child consumes 100 to 140 micrograms in the normal diet. So that will leave him only about 150 to 200 micrograms maximum of lead that he can get from other sources, and a chip of paint of 1 centimeter square with half a percent of lead one layer thick, will provide this.

Now, if you go down to the 0.06 percent which has been recommended by some people, it would take seven or eight layers of paint 1 centimeter square, a chip, to provide two-thirds of the allowable daily intake.

So what we are talking about here is protecting our children of the future. So in 20 or 30 years from now, if I am still alive, I will not have to come back here and testify again to the hazards of lead paint poisoning.

So perhaps if you look at it from the two points of view, it might make it more clear.

Mr. **Preyer.** Mr. Chairman, I might suggest that would be very helpful to have in the record.

Mr. **Florio.** If you will submit that, with unanimous consent, it will be entered in the record.

[The information referred to follows:]

EXPLANATORY NOTES: LEAD CONTENT OF PAINT

1. The Injury Control Laboratory has measured weights per unit area per layer of an interior and exterior paint. The weight of a single layer when applied by four investigators varied between 5 to 8 mg/cm^2; the value of 6.5 mg/cm^2 is used as an "average" weight. Similarly, 16 mg/cm^2 is used as an "average" weight for exterior paint.

2. The second column of the table "Lead/cm^2/layer" is given by the first column, percent paint content times weight of paint chip.

3. The daily permissible intake (DPI) of lead is 0.300 mg. If the lead intake per day exceeds this value, the child cannot excrete the total amount and accumulation in the body begins. A reasonable estimate is that approximately one-third, 0.1 mg, is taken in the diet. This leaves a maximum of about 0.200 mg per day that can be taken in from nondiet sources of lead (such as paint chips) if the DPI is not to be exceeded. In the table, columns 3, 4, 5, and 6 show the number cm^2 (or $in.^2$) of 1 and of 6 layers of paint with various percentages of lead that will contain 0.200 mg lead.

4. Column 7 relates the number of layers of paint with various concentrations of lead that will contain 0.03 mg/cm^2. This is recommended as a maximum or limiting value for a painted surface regardless of the number of layers that have been applied. Two to three layers of a 0.20-percent lead content paint is roughly equivalent to 0.03 mg/cm^2 ($0.03\ mg/cm^2 \div 0.013\ mg/cm^2 = 2.4$, i.e., lead content equivalent of 2.4 layers of 0.20-percent lead paint in 1 cm^2).

TABLE 1.—LEAD CONTENT OF PAINT, VARIOUS DESCRIPTORS

Lead content percent	Pb/cm^2/layer (milligrams)	No. cm^2 to contain 2/3 DPI* (supplemental nonfood lead)		Layers of paint containing 0.030 mg/cm^2 (layers)
		Cm^2	In^2	
Interior paint (weight: 6.5 mg/cm^2/layer):				
1.00**	0.065	3.1	0.48	<1
0.50	.032	6.2	.96	1
0.20	.013	15.0	2.32	2-6
0.06	.004	51.3	8.90	7-8
0.03	.002	102.6	15.90	14-16
Exterior paint (weight: 16.0 mg/cm^2/layer):				
1.00	0.160	1.2	.19	<1
0.05	.080	2.5	.39	<1
0.02	.032	6.3	.98	1
0.06	.010	20.8	3.24	3
0.03	.005	41.7	6.50	6

*DPI = Recommended maximum daily permissible intake (0.300 mg/day): ~1/3Pb in food; non-food lead not to exceed 0.200 mg/day.

**Maximum content in industry standard Z 66.1 (1955) (1964).

Note: Last digit of values rounded.

Source: Child Lead Hazard Evaluation—Barry King, Ph. D.

Mr. **Preyer.** I want to thank you, and I have just one more comment. I can understand your ambiguousness about endorsing the categorical programs. We all, I think, on the committee would rather not have categorial programs, but in many instances, and this seemed to be one, this is what we have to do——

Dr. **Curran.** I am afraid so.

Mr. **Preyer** [continuing]. To get something done in the area. Thank you very much.

Mr. **Florio.** Dr. Carter.

Mr. **Carter.** You really believe that appropriations, or authorizations which precede appropriations, should be based upon morbidity and mortality of the economic impact of diseases; is that correct?

Dr. **Curran.** I think that they do have to be based on morbidity when you are talking about a disease like lead poisoning that carries with it permanent damage. If I were talking about a disease that could be handled very easily, German measles, not in relationship to a pregnant woman but the child itself, when the child gets German measles, it is a very minor illness, and the child recovers. That is one aspect.

If you are going to talk about permanent damage, damage to the mother's unborn baby, that is a permanent situation; that is another aspect.

With lead poisoning, we know these children are permanently damaged. I think in those cases you must consider the amount of morbidity. I think even from an economic point of view, these children are going to grow up to be citizens someday, that you hope will be productive; and if you diminish their capabilities, you are going to reduce their productivity.

Mr. CARTER. The toxic level which you mentioned, I believe, was 80 micrograms per——

Dr. CURRAN. Eighty micrograms is considered an emergency level. Any level can be toxic to a given child. We consider 80 micrograms the point where you go in as an emergency and begin to treat that child without waiting for a lot of laboratory tests. But we feel that lower than that——

Mr. CARTER. At what level do you get stippling of the cells?

Dr. CURRAN. I am sorry?

Mr. CARTER. At what level do you get stippling of the red cells?

Dr. CURRAN. Stippling of the red cells is a very poor test. We used it many years ago because we had nothing more available to us. If a child has 60 to 80 micrograms of blood lead, he probably will have some stippled red cells. He may not. Children with lower levels of lead may not have stippled red cells. I think if you will look at some of the newer statements that are coming out and some of the newer criteria used to make the diagnosis, stippling is not even mentioned any more.

Mr. CARTER. Have you resources, financial and otherwise, that are sufficient in your work?

Dr. CURRAN. Yes; as far as my aspect of the program is concerned, from the Department of Health point of view, we carry it up to the identification of the child, the investigation of the source, and the monitoring and followup. I would say, yes, that if we can maintain the level of funding we have now, we can carry out our program. The other half of it is the Housing and Development Administration that has been charged with doing the repair work. I am not as acquainted with their funding as I am with my own, but I would gather from the responsiveness that we get from them, and from their limited ability to repair all of the sources, that it is not adequate, but I cannot really testify to that aspect of it.

Mr. CARTER. Do you have any statistics on the present incidence of lead poisoning in New York City—lead paint poisoning, rather—as compared with the incidence just before the program began?

Dr. CURRAN. OK. The incidence that we have now is approximately—wait, I will get the exact figures for you.

Mr. CARTER. I believe you have 250,000.

Dr. CURRAN. Those are 280,000 children who are at risk.

Mr. CARTER. 41,000 of those are probable?

Dr. CURRAN. Who possibly have either iron deficiency or lead poisoning. Thirty thousand would have some degree of lead poisoning. But this now is again approximate. I am going to give you an exact figure. Of the 54,305 that we have screened so far this year, 4,827 were identified as class II, which is the low risk group; 846 in class III, which is a high risk, extremely high risk, group; and 186 with unequivocal or frank lead poisoning, the 80 micrograms that we discussed. Those are actual figures out of the 54,000 we screened. With the addition of the 2,129 that I mentioned, that were identified as possibly having iron deficiency anemia, which gives us almost 8,000 children that were identified as needing some kind of medical attention.

Mr. CARTER. How does this compare with the figure of, say, 5 years ago?

Dr. CURRAN. The difference that I am noticing is that we are getting a greatly decreased number of children with 80 micrograms and above, and a decreased number of children with 60 micrograms and above, largely I think because of our vigorous screening. We go out and get these children right in their home environment, and also we do carry on an extensive educational campaign. However, we are still seeing virtually the same number of children that are being exposed and picking up low blood lead levels every year because it is very difficult to attack the source of lead, which is the 400,000 apartment units that we have in the city.

Mr. CARTER. Then you think there has been some improvement?

Dr. CURRAN. There has definitely been an improvement. The first year of the program there were 2,800 children that had 06 or above lead level. Last year there were about 500 that had 06 or above, or 60 micrograms. I am sorry. I am giving you two different classifications; 60 micrograms or above.

Mr. CARTER. Do you think that many children are getting lead poisoning or many of our citizens are getting lead poisoning from fumes or exhaust from cars?

Dr. CURRAN. All right, at the moment we cannot determine how much that is adding to the child's body burden of lead. Let me answer you this way. Yes; I think we are definitely getting an increase in the amount of lead in the average citizen, particularly the urban dweller, because of the auto exhaust fumes and other sources of lead. However, how much this actually contributes to the body's lead burden is extremely difficult to determine. It can be done by tissue studies but at the moment we are not in a position to try to biopsy these children. So to give you an exact answer. I cannot say, but we do feel it certainly does contribute to their background body level, upon which they build when they begin to eat paint chips.

Mr. CARTER. You could do a blood test on these?

Dr. CURRAN. The blood test will tell you what the level of lead is but it will not tell you where it came from. Tissue biopsies which have been done on animals do tell you whether it comes from auto emissions or paint. There evidently is a difference in the character of the lead. This is documented in other literature, I cannot tell you what it is exactly, but I do know tissue biopsy studies will be able to tell you what the source of the lead is, be it auto emissions or something that has been ingested from the diet.

Mr. CARTER. Yes, ma'am. Of course, we are diminishing the amount of lead in the fumes of automobiles, as you know, since we have gone to nonleaded gasoline in the past few years. I hope that that would diminish, too.

Are there any other problems which you have had in carrying out this program? What could we do to assist you with your problems?

Dr. CURRAN. Yes, sir, I really feel that the housing issue has to be attacked and I know this opens up a tremendous problem area because of the magnitude of it, but I really feel that the housing aspect has to be addressed, if not at this time eventually at some time in the future, because until we can get rid of most of these substandard buildings, or at least repair them to such a degree that the lead is not available to the children, we are going to continue to have a problem, which again indicates that we must also stress our educational programs. I think those two aspects, the educational program and hazard abatement have to be strongly addressed.

Mr. **Carter**. Thank you very kindly for an excellent statement. I feel that you have the support of this committee.

Mr. **Florio**. Mr. Hefner.

Mr. **Hefner**. Thank you, Mr. Chairman.

As you stated in your statement, you are familiar with the city of New York.

Dr. **Curran**. Yes.

Mr. **Hefner**. And you mentioned that there are some 400,000, I believe——

Dr. **Curran**. Apartment units.

Mr. **Hefner**. And you say that there are some 200,000 children that——

Dr. **Curran**. That are at risk.

Mr. **Hefner**. That inhibit——

Dr. **Curran**. Yes, sir.

Mr. **Hefner**. And you would probably have the same problem in, say, a city like Chicago?

Dr. **Curran**. Oh, yes.

Mr. **Hefner**. Los Angeles, Charlotte, N.C.?

Dr. **Curran**. Definitely.

Mr. **Hefner**. And I am very much in sympathy with what you say because it seems to me that here in a disease of which we know the cause.

Dr. **Curran**. Right.

Mr. **Hefner**. And which could be eliminated. But the problems are tremendous because these units, these houses, these apartments, even though they are repaired, the repairs will not last in the areas where they exist. It seems to me that it is such a tremendous problem that we are going to continue to have the spawning grounds for as long as these apartments and these houses exist, not only in the larger cities like New York and Chicago, but in some of our rural areas as well.

Now, while it would be more serious in your urban areas, do you have any statistics for the rural areas, like sections where homes have been standing for a long, long while in small communities? Is the hazard there as great as it is in the larger cities?

Dr. **Curran**. Yes; on a percentage basis no matter where you have the older homes, the only time that you would have no problem would be perhaps in—I am just talking off the top of my head—perhaps in some older farm communities where they did not do much painting, if it was an area where the homes were left or the barns were left in a rather natural state. Then, of course, you would not have a problem. But any place where they used the leaded paint, and now they have an older home that is not as well maintained as it was originally, you will have the problem.

Again, it has to be one of magnitude but the rural areas indeed are affected. I do not have any absolute statistics for you to tell you that *x* number of children were picked up from country areas. I am sure those statistics are available. I just do not happen to have them. But any place where you are going to have homes, barns, or equipment of any sort, that was painted and well maintained at one time and now has been allowed to deteriorate slightly, you are going to have a problem, particularly if you have small children running around and particularly if these children develop the habit of pica. Many of the rural southern areas particularly are in danger because many of the small rural children develop the habit of pica to a much greater extent than some of the urban children. It seems to be a rural southern habit that is perpetuated from generation to generation, so you are going to have the problem everywhere.

Mr. HEFNER. Is there any kind of program that you have to educate young parents?

Dr. CURRAN. Yes, sir.

Mr. HEFNER. To be on the lookout for children?

Dr. CURRAN. Yes; as a matter of fact, we have carried our program even lower than that. We have developed slides, movies, various educational materials that go into the junior high and high school area because, not only will these children eventually become parents, but many times, in our urban areas these are the guardians of the children. The older brother or sister is charged with the responsibility of watching the child many times. So we feel that if we educate these children now, before they become parents, we may get in early enough to stop development of this illness.

Mr. HEFNER. It would appear to me that, as the last witness we had stated, there is a real need for education in this area just as much as the technology.

Dr. CURRAN. Absolutely. We have quite a bit of technology now, and if we implement the technology that we have, and if we can educate our population to the services available to them; yes, that is definitely a need.

Mr. HEFNER. This may be a silly question. I can remember when I was a kid, it has been some few years ago, and we were always cautioned do not eat the mud pies and this type of thing.

Is there any training that you would suggest for parents of young children to discourage youngsters from putting things into their mouths? Maybe youngsters are encouraged many times before with pacifiers and this type of thing, things you give them to keep them quiet. I wonder if this would have a tendency to encourage children to put things into their mouths.

Dr. CURRAN. Yes; I understand what you are concerned about. During the stage of a child's development, though, it is very normal to put things in their mouths. This is part of their normal growth and development and it is how they learn about the world around them. Normally, this is a transient stage and does not persist and really causes no trouble.

It is the child who, for one reason or another, develop this compulsive searching. There have been studies to show even this is not a single entity in itself. There seem to be two, or maybe three, forms of pica, in that there are some children who will respond quite nicely to iron therapy and their pica will disappear. There are other children who will show no response at all. There seem to be almost two distinct categories. One that might possibly be due to some type of nutritional deprivation of one sort, maybe not completely understand at the present time. The other appears to be due to maternal deprivation or emotional deprivation of one sort of another. And that is one that could be controlled with education.

Mr. HEFNER. Thank you.

Mr. FLORIO. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman. Dr. Curran, I again agree with my colleagues, your statement has been most enlightening.

Dr. CURRAN. Thank you.

Mr. HASTINGS. You obviously know what you are talking about. Many of us here do not.

Just a couple of questions. One, I would like to follow up with reference to the gentleman from North Carolina that it would be extremely helpful as to the incidence of lead poisoning in other cities, other countries, and certainly the rural areas.

Dr. CURRAN. Yes.

Mr. HASTINGS. There is a lack of sympathy and understanding on the part of the problem of New York City in the last few years here in this body of individuals and I would just like to, from a pragmatic point of view, have it indicated that in fact, it is a problem that transcends just the city of New York. I think that might be helpful.

Dr. CURRAN. I do have a figure that was quoted back in 1972. It was a mathematical model, though. The reason I did not give it to you is just for that reason, it is a mathematical model.

Back in 1972 it was estimated that approximately 600,000 children would have an increased blood lead content at the 40 micrograms or above, and that 2.5 million children would be at risk. I would, from my own experience, say, if anything, that is a low estimate, particularly from the figures that we have been getting from the city.

Mr. HASTINGS. Well, I understand that you are testifying on behalf of the Urban Environment Conference?

Dr. CURRAN. Yes.

Mr. HASTINGS. I would think that they certainly would have figures available from throughout the country.

Dr. CURRAN. Yes; but as I say, it is a mathematical model. I do not know if they have any current figures but——

Mr. HASTINGS. If they do, it would be helpful.

Dr. CURRAN. Yes, sir.

Mr. HASTINGS. Your specific recommendations are that, as I understand from the first page of your statement, to let paint poisoning prevention be removed from title II and that a separate title be created. What would you suggest for funding levels and how the grants should be handled?

Dr. CURRAN. I have read the Senate bill and it seems like a rather realistic level of funding that has been mentioned there. I do not have it in front of me. But, my impression when I read it was, if we could get that type of funding for our program, that we would certainly be able to operate a well-run well-structured program.

Mr. HASTINGS. And how would we handle the grants, how would you suggest we handle the grants, should they go to the States, should they go to the municipalities directly?

Dr. CURRAN. All right. The way our grants are handled now is they are handled by the various regions. CDC decides basically what each region will get, then the region itself decides which program and which project will get specific funding. This seems to be a reasonable approach, because the people in the regions are well aware of the magnitude of the problem in each of the various areas; they are also aware of the management capabilities, the productivity of each of the programs in the regional areas, and, I would say, that this is a realistic and reasonable way to continue, that it be done on a regional basis.

Mr. HASTINGS. How does money filter down into the rural areas with that kind of approach?

Dr. CURRAN. Well, all right, the rural areas, of course, are involved in these regions. For instance, region 2 takes in much more than New York City, it takes in all of New York State. So the rural areas would be involved as well as the urban, and the various regions should be aware of the magnitude of the problem in their specific area.

Mr. HASTINGS. How much of an input should there be from the State Health Department?

Dr. CURRAN. I think that there has to be a considerable amount of support, perhaps a lending of expertise to some of the newer projects. Many times the State has to provide the laboratory capabilities because the smaller projects are not capable of doing it themselves. I think it has to be a hand in glove type of thing. The small projects in particular must work very closely with the State.

Mr. HASTINGS. This is not a loaded question but one of some interest. Staff has indicated to me that a few years ago there were walls in the Lincoln Hospital in south Bronx pediatrics ward that were covered with lead based paint.

Dr. CURRAN. Yes.

Mr. HASTINGS. And it created some problems, as a matter of fact. Has that been taken care of?

Dr. CURRAN. Yes. This occurred very early in the program and it was not just Lincoln Hospital, they found it in Bellevue and a few others, too. It is not a loaded question, it is a reasonable question. We have now gone out and checked all of the areas where it is likely that children would be involved in being retained for any length of time. We have gone to the foundling home and so forth. As a matter of fact, just this week I approached the Bureau of Child Welfare with the possibility that whenever they are planning to place a child for foster home care that, before they do that, they allow us to go in and examine the environment to be sure they are not taking a healthy child, who has many other problems already being a foster child, and putting him into a home that is contaminated with lead. So we do make those provisions and we are hoping to extend that capability so that we can provide this kind of service to other facilities in the city.

Mr. HASTINGS. Fine. I thank you very kindly. Your contribution will be helpful to the subcommittee.

Mr. FLORIO. If I could just ask a few questions in order to get an understanding as to the distribution process of these grants.

Your project apparently is in New York City, you are the grantee, you make application to the district office?

Dr. CURRAN. We make application to the regional office which is the Federal building in the city, but it is the regional office for the entire region 2.

Mr. FLORIO. And your moneys do not have to be cleared through any State agency?

Dr. CURRAN. They have to be cleared, I believe, through the region and then they go through the comprehensive—I am not going to give you the right name—comprehensive health planning and they must be cleared at this level then, of course, they do go to the CDC and further on up the line.

Mr. HASTINGS. Calling upon your prior experience from the record in New Jersey, are you aware of how it works in New Jersey?

Dr. CURRAN. I believe——

Mr. FLORIO. Most programs there do not provide for direct access by the project to the regional office but rather go through the State Health Department with the State Health Department being the grantee and making appropriate decisions as to which of the different projects——

Dr. CURRAN. I believe that is changing, though, because I know the Hoboken area has a direct grant from region 2 and I believe that they are at the moment expanding this to include the Jersey City area which again will be a direct grant. It is the same grant, the Hoboken grant through region 2. Possibly that was the way it was done originally but even that, I believe, eventually comes through region 2.

Mr. FLORIO. Do you feel it is preferable to have the project make direct application to the region rather than going through a State agency?

Dr. CURRAN. I think in a sense I probably have misled you. I think in a sense, we do go through the State in the sense if the comprehension health planning group for the State disapproves of our application, I do not think the region would move on it.

Mr. FLORIO. I am familiar with the comprehensive health planning service and I do not think this is really what I am talking about. We had testimony yesterday on the rodent control program in New Jersey. Under that program the State makes an application to the Federal Government, the appropriate regional office of HEW, they get money, they then decide upon which of the cities in the State of New Jersey are going to be eligible for the rodent control program with the Federal Government merely overseeing, so to speak, the substantive decision is made by the State agency. That is not the way this works, I understand.

Dr. CURRAN. Not the way it works with us, no.

OK, to answer your question. As far as I am concerned—and again, I must speak strictly for myself—I think that at the present time the grant being made to the regional, or application being made, is sent from the project itself to the regional office, is the way that I think would be the most beneficial way for it to function. Then you would have a direct contact between each of the individual projects and the region without having the layer of the State in between, which might compound the issue by a lot of other problems if the State would interfere with——

Mr. FLORIO. What is New York City doing, to use your experience, with regard to housing codes so as to upgrade the quality of the care that is given to the homes?

Dr. **Curran.** The housing code that relates directly to us indicates that if a child with elevated blood lead and/or erythrocyte porphyrin is detected, his home must be made hazard-free to the extent that 0.5 percent or greater leaded paint is not allowed on the walls. That is the only direct code that applies to us. However, there are many other housing codes, and the Department of Health is involved with several of them, such as the water problems and so forth, in the homes.

So what our sanitarians do when they go into the home to make an inspection, they do not limit their inspection particularly to the hazards of lead paint; they inspect the entire home for all sorts of housing violations, whether they come under the health code or not. And a separate report is made to the Housing and Development Authority indicating what hazards are found and what recommendations we have for repair.

Mr. **Florio.** So your screening process not only uncovers children but you have impact?

Dr. **Curran.** Housing problems.

Mr. **Florio.** To what extent?

Dr. **Curran.** Even to the extent that if they notice that the child lives on the second floor and the windows are not properly guarded with screens or bars, or what have you, that is also reported.

Mr. **Florio.** Is there followup in compliance with these changes required?

Dr. **Curran.** Yes.

Mr. **Florio.** I wonder if you could just briefly give me an indication as to actual screening process. Are you saying you have a worker out on the street going door to door?

Dr. **Curran.** In the summer. The majority of screening takes place in the baby station, well-child stations, and ambulatory care facilities, the health maintenance organizations, that have been set up in the city. Private physicians do some screenings in their offices, but during the summer months we literally go out into the streets and we have the campaign set up with mobile vans and go into our lead belt areas. We have advanced notice that we are going, we send out outreach workers out ahead of time to alert people to the fact we are coming and we work, of course, through the district, so we do not have a duplication of effort, and we then screen the children on a door-to-door basis, and we actually pick up a greater percentage of positive cases that way than we do through our other screening.

Mr. **Florio.** This is essentially a blood test?

Dr. **Curran.** It is a finger prick blood test.

Mr. **Florio.** Other than the appropriation level consideration, do you have any suggestions as to what can be done to improve the statutory implementation of the program? Are you satisfied with the program but for the proposed reductions in the appropriations?

Dr. **Curran.** I am satisfied with my program. I do not know what else I can tell you.

Mr. **Florio.** Let us assume everyone is not sophisticated in initiating a new program in this area. Are there improvements that could be made to the statutory authorization for the granting of these funds other than the amount of money and, if there are, and if we do regard this as a problem, we have gentlemen from rural areas that would perhaps want to encourage their areas to take advantage of these things.

What can you suggest to make this approach more acceptable and much more able to be utilized ably, if anything?

Dr. CURRAN. Yes. The only aspect again that I would say that perhaps has not been stressed sufficiently, of course, the rural areas perhaps have not had mention made of them sufficiently to alert people to the problem. That is probably true. I think really, the biggest lack has been the stress on moneys for hazard abatement.

I do not know whether or not that is what you want me to say.

Mr. FLORIO. I do not want you to say anything you do not want to say.

Dr. CURRAN. That is the topic you wish me to address?

Mr. FLORIO. I suspect what I am asking for, is there any improvement that you can suggest in the existing way that this program is administered, not at your end, obviously there is some discretion, some initiative that can be shown there, but at this end, that is, in terms of the statutory authorization. Is there anything that we can do and perhaps it is unfair to ask a complicated question like this—any improvement in the program that could be effectuated by modifications in the language, by the inclusion of new elements into the language, we would appreciate receiving that.

Dr. CURRAN. That would be fine because, really, without restudying what I have read for the first time Friday, I would have a difficult time, the bill, I would have a difficult time commenting on that.

Mr. FLORIO. My last question. Yesterday when the officials from the HEW were here they were advocating a 66-percent cut in the funding for this. I suspect probably you do not agree with that?

Dr. CURRAN. No.

Mr. FLORIO. They justified this proposed cut on the ground that if the Federal Government involvement is reduced we can fully expect the private sector and State and municipal governments to pick up the portion that is going to be proportionately reduced. What is your thought?

Dr. CURRAN. Well, from my own point of view and from the fact that I come from New York City, I obviously think that is ridiculous. I do not see any way that at this particular time the city is going to be capable of stepping in. The city already contributes two-thirds of the funds to our particular program. I do not see any way that they are going to be able to step in and fill the gap if the Federal Government pulls out. I do not see the private sector at this particular time being able to come in and fill that gap either. I think if the Federal Government pulls out, at least from my point of view, it is going to be disastrous. I do not see how we can continue without the additional support of the Federal Government.

Mr. FLORIO. You made reference before to the Senate level of funding. I am not exactly familiar with the Senate level of funding. Do you have a figure?

Dr. CURRAN. I do have it over here.

There was a specific breakdown I wanted to give you. I know there was a request or recommendation to keep the level of funding, the total level of funding at, I believe it was the $12 billion mark, but there was a breakdown in the Senate proposal.

Mr. FLORIO. I can find it.

Dr. **Curran**. It is here. I will dig it out later and leave it if you wish.

Mr. **Florio**. Thank you very much.

Dr. **Curran**. I do not want to keep digging around. The figure that was just handed to me, and the one that I am acquainted with, is the $12 million figure, but there was a breakdown as to what would be allocated for screening, what would be allocated for medical monitoring, medical management followup, and what would be allocated for hazard abatement.

I do have it with me and I can leave it.

[The following information was received for the record:]

S. 1664 Level of Funding

$18 million authorized for 1976, allocated as follows: (a) $10 million for title I, screening and treatment; (b) $5 million for title II, hazard elimination; (c) $3 million for title III, research.

Mr. **Florio**. It is your recollection it was approximately $12 million?

Dr. **Curran**. It seems to be adequate. Again, as I say, my experience has been very provincial despite the fact we are talking about New York City, which is an extremely large city. I am still talking from my own limited experience from the one area.

Mr. **Florio**. We do appreciate your comments. It has been very helpful.

[Whereupon, at 12 o'clock noon, the subcommittee was adjourned.]

NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

MONDAY, NOVEMBER 10, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2167, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. Rogers. The subcommittee will come to order, please.

This morning's hearing is on title I of H.R. 8278, the National Health Education and Disease Prevention Act of 1975. It is also on similar or identical bills including, particularly, H.R. 5839, the National Health Education and Promotion Act of 1975 which was developed by our own ranking minority member, Dr. Tim Lee Carter before I introduced H.R. 8278, and represents a truly pioneer effort in this area for which Dr. Carter is to be complimented.

This legislation serves more than one purpose. It revises and extends the existing authority for disease prevention and control programs through title II on which hearings were held on last week. It creates new legislative authority for programs concerned with health information, education, and promotion for the public; new programs in preventive health services; and new programs intended to provide public education in the appropriate use of medical care. In our work on health care in this country we often hear the common complaint that people don't know what kind of medical care to seek, when to seek it, how to judge its cost or quality, how to take care of themselves—either to maintain their own health or respond properly to whatever diseases they may have, what preventive health services they should use with what frequency, or what effects medical treatment and drugs may have upon them. This proposed legislation responds to these complaints with a wide variety of new authorities intended to open the health care system and the knowledge which it possesses to the public and make it increasingly possible for people to take care of themselves and use the health care system effectively and appropriately.

These are fundamental concepts to the health of our population. With medical care costs rising at a rate of 10 to 20 percent per year and with total expenditures now exceeding $100 billion, it is reasonable to look for some improvement in our people's health, but by all indications we have not yet seen much results. Gradually we have come to understand that this is because we must rely more on each individual's own efforts to behave in ways which will keep him healthy and take care of his own needs and diseases effectively. If this is to be accomplished, then we must begin to make it possible through educational and other support programs. H.R. 8278 represents an important first step on this road and I am pleased to be able to begin hearings on it.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Yes.

Mr. CARTER. I have some visitors of whom I am extremely proud today that I would like to introduce to this group: Dr. Carey Sykes and the students with him from Berea College. Would you all stand up, please.

Mr. ROGERS. Dr. Sykes and students, we welcome you to the committee. We are very pleased to have you here and I am sure you realize the important role that Dr. Carter plays on this committee, and I think it is very appropriate that you should be here at the hearing today which will be on legislation that he has proposed.

Mr. CARTER. Thank you, Mr. Chairman.

I might say that Berea is a college which was established in 1954, in southern Kentucky, to provide the educational opportunity for mountain youngsters and others who were disadvantaged. It is a great school. Each youngster is required to work an average 10 hours a week, and I wish we had more schools like Berea. I am certainly happy to have Berea in the district I represent.

Mr. Chairman, if I might take just a minute on our legislation.

I am very pleased that our subcommittee is holding hearings on legislative proposals to set forth a national strategy with regard to education for health promotion and preventive medicine. I certainly want to commend the chairman, Mr. Rogers, for conducting these hearings on this very critical and timely issue.

As a practicing physician for quite a few years—I know first-hand of the tremendous value of health education and preventive medicine.

We have long targeted our national health efforts toward methods for improving the diagnosis and treatment of disease—I would in no way disparage such efforts because they are absolutely essential.

However, I am pleased at the increasing awareness and concern for preventing illness and maintaining health. In fact, in recent years it has become more and more evident that only by preventing disease from occurring, rather than treating it later, can we hope to achieve any major improvement in the Nation's health. Support for this approach is not without rationale, particularly—in light of the cost effectiveness of health education.

We have sold our society on the wonders of modern medicine and we have created an insatiable demand for services. In 1974, the amount spent on health care in this country went over the $100 billion mark for the first time.

Yet, despite our presently huge outlays in dollars and resources, our health indicators reveal that we are not getting our money's worth. We have more physicians per capita than any other country in North America or Europe and yet, at each age from infancy into the seventies, the rate of death of Americans is almost the highest in the developed world.

If our health indicators reveal we have gained little benefit despite tremendous investment in health services we must ask ourselves why this spending is failing to produce the desired results.

I submit that the answer may lie in the changing nature of disease. Until the early decades of this century, the major health problem in our country was communicable disease. Pneumonia, influenza, and tuberculosis were the leading killers.

Today, the principal causes of death in our country are heart disease, cancer, stroke, accidents, respiratory diseases, and suicide. A distinctive feature of these conditions is that they are related to the environment and our changing life styles—which are not susceptible to direct medical solution. Self-imposed risks, and environmental factors are the principal or important factors in each of the five major causes of death between ages of 1 and 70.

To change these unhealthy patterns of behavior requires the active involvement of the individual—an enlightened individual—who is aware of his role in disease prevention, and committed to improving his health.

Therefore, I contend that if we are to effectively improve our level of health in this country, we must turn to a new strategy that will assist us to understand the nature and causes of self-imposed risks, adds to our knowledge of illness, educates patients and consumers about health maintenance and preventive medicine principles, and helps improve the physical and social environment.

It was in response to the need for such a national strategy that I introduced H.R. 5839, the National Health Education and Promotion Act of 1975, which has been reintroduced with cosponsors as H.R. 6549 and H.R. 8995.

At this time, I would like to thank my distinguished colleagues who joined me in cosponsoring this bill: Mr. Brown of California, Mr. Conyers, Mr. Downey of New York, Mr. Eilberg, Mr. Florio, Mr. Koch, Mr. Matsunaga, Mr. Preyer, Mr. Solarz, Mr. Symington, and Mr. Waxman.

I offer this contention in full recognition of the very fine individual efforts that have been made already by various agencies and departments within Government and by various private organizations.

However, there has been no focal point to facilitate communication and cooperation among the significant health organizations in and out of Government.

H.R. 5839 would provide the mechanisms for a coordinated, major long-term commitment by both the public and private sectors of our society to health education and promotion.

This approach would entail establishment of a National Center for Health Education and Promotion within the Department of Health, Education, and Welfare.

This national center would have four divisions with individual responsibility: For research in health education and preventive medicine, for community health education programs, for communications in health education, and for Federal programs.

In addition to the National Center for Health Education and Promotion there would be established an institution for health education and promotion. This institution would be created as a nonprofit corporation for facilitating development of a health education and promotion strategy. This institution would have a 25-member board of directors appointed by the President in accordance with requirements that they represent the fields and concerns of health education, health care services delivery, nutrition, general education, consumer representation, and advocacy, communications, labor and business, planning and organizational management, and public and private finance.

The board of directors would appoint an advisory panel of 200 individuals with appropriate competencies and abilities to aid the board in its efforts. The institution shall submit an annual report to the President and Congress, and shall be audited annually.

I submit that this approach maintains the proper mix of public and private efforts necessary to effect and sustain a national health education and promotion strategy that is broad-based and comprehensive enough to fulfill our goals. My bill would establish a formal, statutory connection between the National Center and the private, nonprofit institution which I believe is critical for effective implementation of such a strategy. With the assistance of Federal funds, and with support from the private sector, this institution will be able to stimulate, sponsor, coordinate, and support the development of new health education initiatives and programs. It shall function in a complementary role to the Federal effort, with the appropriate linkage necessary to maintain independence and still assure desired communication and coordination.

Through such a cooperative effort, I believe we can capitalize on the strengths and resources available to each of the public and private sectors.

Working from a similar framework of principles, which I have just outlined, the Senate has given its approval to health education already—the National Disease Control and Consumer Health Education and Promotion Act, S. 1466, sponsored by the distinguished Senator from Massachusetts, Mr. Kennedy.

I should like to commend the Members of that body for their recognition of the great need for such an approach to improving the health of our citizens and for their recognition of the merits of a coordinated, comprehensive strategy involving the public and private sector in carrying out health education and promotion.

Today, we begin to hear testimony of health education proposals here in the House, H.R. 3205, H.R. 5389, and identical bills, and H.R. 8278. Taken together, these bills encompass a number of possible approaches to achieving effective health education policies and programs for the American public, as well as provisions for disease prevention and control.

Mr. Chairman, I welcome these hearings as a forum for discussion. It is my hope that they shall serve to bring about in-depth examination of the various alternatives for health education and promotion.

I trust that with the assistance of expert testimony, the guidance of the staff, and the wisdom of our distinguished colleagues that we shall indeed arrive at the best possible approach for furthering the potential for enhanced health and well-being of the American people.

Thank you, Mr. Chairman.

Mr. Rogers. Our leadoff witness this morning is the Honorable William S. Cohen, of Maine, who has taken a most significant interest in this subject matter and has introduced legislation, H.R. 3205, along with Mr. Hastings, of New York, entitled "The National Health Education Policy and Development Act."

We welcome you to the committee. Your statement will be made a part of the record at this point in full, and you may proceed as you see fit.

STATEMENT OF HON. WILLIAM S. COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. COHEN. Thank you, Mr. Chairman.

First, I would like to say I welcome the opportunity to be the lead-off witness before this distinguished subcommittee on the vital subject of health education. Despite my concern for other aspects of health care, I have been most interested in the lack of attention we have given to health education, and I am delighted that, true to correspondence I received last year, you are exploring health education possibilities. As a sponsor of health education legislation, I appreciate the opportunity to submit my views on the merits of a national health education policy program.

Aristotle is credited with saying, "If we believe men have any personal rights at all as human beings, they have an absolute right to such a measure of good health as society, and society alone, is able to give them." Whether or not we agree with the essence of this statement, health care in America is likely to become a right rather than a privilege with the probable enactment of a national health insurance program. Since traditional financial barriers will no longer define who receives the assistance of our limited health resources, we will be faced with two choices: We can either ration the available service in one way or another or make a deterimned effort to reduce the demand on the system through high-priority attention to health promotions and health education. Thus it is with a certain degree of urgency that we address this issue.

Health education aims at endowing people with a heightened sense of the value of good health, as well as demonstrating that good health is in large measure a matter of personal responsibility. If national health insurance comes to pass, the strain on the health-care economy, especially the medical profession, could become intolerable without a massive prevention and educational program. Government and providers of health and human services have a responsibility to work closely together to insure that the best system is developed. The public interest demands no less. Toward the end, funding must be made more available for alternative approaches to health-care delivery—focusing on those which are both human-effective and cost-effective.

Health education is a valuable means of containing skyrocketing medical care costs because it offsets current incentives to overutilize expensive health care service. Health care costs will increase by an estimated 14 percent this year alone, from $105 billion in fiscal 1974 to over $120 billion in fiscal 1975. The Federal Government's contribution to personal health care has risen more than 600 percent, from $3.3 billion to $20.1 billion, since the beginning of the medicare program a decade ago.

Despite this vast increase in health care expenditures, the rules of illness, disability, and death have shown little signs of improvement. More importantly, what improvement we have achieved has not kept pace with that of the other Western industrialized Nations.

When we look at social indicators such as infant mortality and death rates, we find that the United States in the decade from 1963 to 1972 fell from 10th to 15th place in the infant mortality category and from 7th to 8th place in death rate.

The tragedy is that a great many individuals are still unaware of their own role in the prevention and relief of ills and accidents, and lack the knowledge required to utilize the health care industry itself. The leading causes of disability and death in this country today are chronic or behavioral conditions, such as heart and respiratory disease, cancer, obesity, alcoholism, accidents, and suicide. Effective control of these conditions is impossible without the active cooperation of an informed population.

Yet, we persist in lifestyles which threaten our well-being. The principal cause of death for persons through age 44 is accidents. Only 60 percent of young children have been immunized against polio, a 3 percent decrease since 1972. Venereal disease has become America's new epidemic. The No. 1 health problem in my own State of Maine is dental caries. With adequate health education, each of these other situations could have been averted. If we are to control our newer epidemics, we must set forth a new strategy, one which assists us to understand the nature and cause of self-imposed risks, adds to our knowledge of illness, educates patients and consumers about health maintenance and prevention, and improves the physical and social environment.

Preventive health care is not a bold new concept. Throughout recorded history, responsibility for health has been placed on the individual. It has only been in the 30 years since World War II that "health" has been equated, in the vocabulary of public policy, with "health care" which can be defined as the pursuit of health with professional care, and more and more dollars to pay for such care.

Our growing medical sophistication is further complicated by the uneven distribution of health resources. This is particularly true in rural areas. Research indicates that even though rural populations will expand, they will continue to be short of physicians and health care facilities. The American Medical Association reports that people in more sparsely populated areas have only about one-half the access to physicians, nurses, dentists, hospital beds, and other health resources when compared with the rest of the Nation. In my own State, statistics suggest that Maine's rural poverty, its scattered and over-worked health care personnel and facilities, and the absence of preventive medicine combine to produce a significantly higher death rate than the rest of New England. While Maine ranked third best in 1940 among the New England States in terms of death rate, by 1970 Maine had the highest death rate of all New England States—19 percent higher than the national average. At the heart of these statistics is the relative absence of preventive care. In a typical rural county, more than 65 percent of the men and women did not have regular medical checkups. One-fifth had never had a chest X-ray. Nearly half the women never had a pap smear.

In addition, during this time of serious national economic stress, health care is one area in which people are trying to save money. In a recent survey conducted by General Mills, 28 percent of those families most impacted by the economy had postponed medical and dental checkups. Despite the unfortunate consequences these decisions may have, our society also suffers when the individual abdicates his responsibility for the treatment of his own diseases and injuries.

The public's growing impatience with the overemphasis on the technology of medicine and the neglect of the patient as a responsible agent in the treatment of illness can be remedied through an effective program of health education. We are on the verge of a breakthrough which will shift the emphasis from costly crisis care to promotion of positive health and prevention of disability.

For example, over the last year we have witnessed the adoption by medicaid and Blue Cross of policies and guidelines to pay for patient education services; establishment of the Bureau of Health Education within HEW; initiation by the National Health Council of a project to develop detailed plans for a private National Center for Health Education; definition by the American Hospital Association of the health education roles and responsibilities of health care institutions; and incorporation of health education in Federal laws on health organizations, emergency medical service system, diabetes control programs, and drug abuse education, not to mention the recent passage of S. 1466 by the Senate, similar to legislation being addressed today.

While the list of initiatives continues to grow, history may well show that the most noteworthy achievement of the past year has been the enactment of health planning legislation, which makes health education one of the nine priorities in the formulation of national health policy and in the development and operation of Federal, State, and area health planning and resource development programs.

We all appreciate the need for an effective program of health education. However, there still exists a huge gap between recognition of the virtues of the prevention of illness and definition of ways to accomplish our desired objectives. I would like to highlight some important features of any health education program which I feel are necessary in order to accomplish our desired goals.

One of the two key recommendations from the President's Committee on Health Education calls for the establishment of a focal point for health education within the Federal Government. With respect to the Federal role in health education, I would like to highlight some important features which I feel are particularly necessary:

First, I would urge that we relocate the present Federal Bureau of Health Education within the Office of the Secretary of Health, Education, and Welfare. Its subordinate location in the Center for Disease Control in Atlanta, Ga., and the lack of visibility and resources contradicts its broad mandate. I feel this Bureau could carry out its major function of coordination more effectively if located administratively at a high level and geographically near relevant Federal agencies.

Unfortunately, even with severely limited resources available for health education, there is considerable duplication and waste. The 10 references in the Public Health Service Act which do apply to health education for consumers are lacking in coordination. At the same time, other laws work in opposition to health maintenance. For instance, any activity that can be labeled "preventative" will not be reimbursed under existing medicare statutes, not to mention our continued policy of agriculture supports for harmful products such as tobacco, or those potentially harmful if used to excess, such as marbelized beef. Coordination makes for the development of comprehensive health education programs which would draw upon the resources of the health systems agencies authorized under Public Law 93–641 to give particular attention to the various cultural health needs of specific ethnic, economic, and geographic population. For example, as a member of the House Select Committee on Aging, I was most disturbed to learn that the elderly in my State consider the lack of information on health benefits one of their most serious problems.

Plans should be formulated to address the lack of manpower trained in health education if a national health education effort is to be effectively implemented. It is my understanding that at present in the United States there are only about 25,000 professionally trained health educators. More are needed. Furthermore, ways must be found to increase the participation of all health personnel including nurses and paramedics, in the health education process.

Fourth, it would probably seem ideal to many of us if we would provide for a more limited Federal role and financing, particularly in light of the Federal deficit. However, the vast majority of the illnesses and injuries which we hope will be alleviated by effective health education programs do not recognize State boundaries and are national in scope. Likewise, at this time, State and local public financial resources are not forthcoming in answer to the problem. In view of the petty Federal response to date—approaching four-tenths of 1 percent for health education—I believe the sums authorized under my own bill are inadequate. Nevertheless, I trust that the subcommittee in its wisdom will use its discretion in this matter.

Finally, the task of evaluation should be considered. Perhaps the most egregious failure to health education programs today is the lack of concrete evidence of the ultimate impact these programs have on the state of our health. For a viable, dynamic program, an ongoing process of evaluation is essential.

Mr. Chairman, I recognize the legislation I authored is one of several options open to you, including legislation introduced by yourself on behalf of the members of the subcommittee. While I was pleased to note the many similarities between our two measures, more important than the future of any specific bill, is the critical need to embody in legislation the concept of health education. We must act to change the daily living habits of our overfed, overtired, overmedicated—in short, overindulgent—society. As economist Victor J. Fuch concludes in his book, "Who Shall Live?" The greatest current potential for improving the health of the American people is to be found in which they do or don't do to and for themselves." In my opinion, this statement is the essence of the case for health education.

I would ask that a letter addressed to me from the president of the Maine Hospital Association be included as part of my statement.

Mr. ROGERS. Without objection, so ordered.

[The letter referred to follows:]

MAINE HOSPITAL ASSOCIATION,
Augusta, Maine, November 6, 1975.

Mr. WILLIAM S. COHEN,
Cannon House Office Building,
Washington, D.C.

DEAR MR. COHEN: It is our understanding that the Subcommittee on Health and Environment of the House Interstate and Foreign Commerce Committee will shortly begin hearings on various bills dealing with health education. Among those bills to be considered are: H.R. 8278 "National Health Education and

Disease Prevention Act" introduced by Mr. Rogers; H.R. 5839 "Center for National Health Education and Promotion Act" introduced by Mr. Carter; and H.R. 3205, "National Health Education Policy and Development Act" introduced by Mr. Hastings and yourself.

The Maine Hospital Association, together with other health-related organizations in the State of Maine, have for some time been meeting to determine the best method of coordinating the many health education programs currently conducted in the state. This group has been working to create a greater understanding of how persons can be encouraged to adopt more healthful behavior and to retain a healthy lifestyle. We have recognized that factual information alone is not sufficient to cause people to change their lifestyles and behavior. There are strong counter interests and pressures to healthy lifestyles, including smoking, drinking and poor nutritional habits. Despite these pressures, we believe health education and promotion an essential part of the effort to improve the health of the people of the State of Maine.

There have been over the past several years, two major studies of the current status and suggestions for the future direction of national efforts in health education. These were the Task Force on Consumer Health Education and the President's Committee on Health Education. The Maine Hospital Association is very pleased to see that many of the major recommendations of these two important independent study groups are contained in the legislation you have introduced, as well as the others that will be considered by the Subcommittee.

We believe that progress to meet these vital needs will depend on a long-term commitment by the public and private sector, at both the State and local level. That is the only way we will be able to improve the health education status of the citizens of the State of Maine.

We would appreciate it very much if you ask that this letter be included in the record of the hearings on these pieces of legislation.

Cordially,

FLETCHER H. BINGHAM,
President.

Mr. ROGERS. Thank you very much for a very comprehensive and effective statement. The committee is very much aware of your interest and the work you have done.

It may be that the committee will have to look at various atlernatives, perhaps just demonstration programs as a beginning.

What would be your reaction to that?

Mr. COHEN. I would support that very much. I think in this field we do have to start off with demonstration programs and grants.

Mr. ROGERS. Maybe we will have to move in that direction.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I just wanted to commend the distinguished gentleman from Maine for his statement and for his excellent piece of legislation which he has introduced. I think it shows very good sense which will be extremely helpful to the health of the people of our country.

Mr. COHEN. Thank you.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you. I congratulate Mr. Cohen, too, on an excellent statement, and I was delighted to learn Aristotle said medical care is a right, not a privilege. I wondered where that started from.

Mr. ROGERS. Thank you so much. The committee is grateful to you for your statement and for your interest.

Mr. COHEN. Thank you very much.

Mr. ROGERS. Our next witness is William Lynch, Jr., who is director of training, New Careers Training Laboratories, Queens College, New York.

The committee welcomes you and your statement will be made a part of the record in full at this point, and you may proceed as you desire.

STATEMENT OF WILLIAM LYNCH, JR., DIRECTOR OF TRAINING, NEW CAREERS TRAINING LABORATORY, QUEENS COLLEGE, CITY UNIVERSITY OF NEW YORK

Mr. LYNCH. It is an honor to appear this morning before the subcommittee and I appreciate this opportunity to testify on a matter of such great importance.

No subject in the broad arena of health care is more talked about and is less attended to than that of health education and prevention. It has long been recognized that to a large extent what we fail to do in education and prevention will only come back to face us as a problem often greatly exacerbated. It is only one of the tragedies of the crisis in New York City that the Health and Hospital Corporation, so ably led by Dr. John Holloman, in order to maintain its "life-preserving activities" must now cut the bulk of its preventive and educational activities. The budgetary pressures which have caused this "solution" surely deserve the label of "pennywise and pound-foolish."

I would like to divide my testimony into two parts. First, I want to talk about the area of health education and disease prevention, particularly about innovative potentials there, and then to talk more briefly about H.R. 8278.

Traditionally, we think of productivity as a function of technology: the more machinery, the more efficient production will be. This has certainly been characteristic in the manufacturing of goods. On the other hand, the services are labor intensive; they use a high proportion of labor or human power in contrast to machinery or capital in order to produce the service product whether it be education health, safety, or personal services. To make the services more efficient, it has seemed natural to try to mechanize them more; that is, to apply machinery so that they will perhaps become more like manufacturing.

There are countless illustrations of mechanization in the service fields—multiphasic screening of patients, teaching machines for pupils, walkie-talkies for policemen, et cetera. While some of these methods clearly have their uses, there has been no leap in the productivity or "humanity" of the services in the areas where they have been applied.

The fact is that there are very few examples of marked advances in output in the service spheres, but fortunately there are a few, and perhaps something can be learned from a look at them.

Of course, there is the problem of definition. What, after all, is a marked improvement in service delivery, and how is it to be assessed? As a working model, we would suggest the following indexes:

(1) The rapid spread in the utilization of a service of "obvious" value; for example, immunization of large numbers of children hitherto uninnoculated;

(2) A strong positive subjective report by users of service wherein the subjective element may be said to be the decisive variables: for example, partners reporting change in the enjoyment of sexual relations subsequent to receiving sex therapy.

(3) Changes in behavior at multiple levels; in education, for example, changes in the cognitive and affective dimensions. An important variant of this point relates to the latent functions of a service. Thus, if in the process of learning to read, a child acquires a more cooperative attitude, a feeling of greater power, et cetera, these added outputs

(frequently emanating from the context of the service) can be seen as important reflections of its value. On the other hand, a service that in itself may produce a positive output—for example, a doctor's accurate prescription for a patient—can produce disastrous consequences if the whole relationship makes the patient feel highly dependent and mystified.

With these criteria in mind, some actual illustrations can be cited. One is the rapid and effective spread of family planning among segments of the population that hitherto were uninvolved in these procedures. Planned Parenthood now estimates that over 50 percent of the poor in the United States are utilizing family planning approaches.

A second area that illustrates marked change in output is one in which children have been *utilized to teach other children. Here, the* older children who do the tutoring have been observed to achieve a dramatic advance in their own learning—as much as 3 years in reading improvement in 6 months' time. These changes have been lasting and are typically accompanied by changes in attitude toward learning, increased self-confidence, et cetera.

A third illustration can be found in various applications of the self-help movement. For example, it has been reported that the most effective approaches to weight control are the various Weight Watchers groups—and to a lesser extent, this seems to be true for smokers, alcoholics, and drug addicts, although the data are more ambiguous than in weight reduction. Of added importance is the fact that these behaviors have been very resistant to change by all methods.

What these examples seem to have in common, in addition to the fact that they are inexpensive, is a special involvement of consumers—patients, students, and clients—so that they become a force in the increase of productivity of the service. The consumers are actually operative in the delivery of the service; it is not some general form of participation. And there is a definite increase in the output.

A number of developments in the health field suggest some of the dimensions of a practice which is consumer, not doctor, centered. Fuchs talks to the issue when he says that the health of our society is far less dependent upon the numbers of doctors or professional personnel and much more dependent upon the attitudes, culture, and involvement of the users of the health services. As he states:

> It is becoming increasingly evident that many health problems are related to individual behavior. In the absence of dramatic breakthroughs in medical science, the greatest potential for improving health is through changes in what people do and do not do to and for themselves.

It is to the issue of affecting these actions of people that a consumer-centered practice must be directed.

The professional-run system with its "doctor knows best" attitude is not only antithetical to a consumer-focused practice, but indeed, there appears to be evidence that it is not effective in terms of patient well-being on standard measures. Glogow found that patients who adopted a compliant, nonquestioning attitude, and who became what hospital staffs call a "good patient," may not be the most likely to get better more quickly. On the contrary, the patients who were less compliant, the "bad patients," do improve more quickly. Doctors who use medical jargon a great deal, and thus fail to communicate with their patients, are less successful in terms of their patients' health.

The disease model of medical care appears to be particularly harmful to women, for their visits to doctors are to a far less extent disease related; for example, regarding birth control, pregnancy, menopause, and—given the common childrearing practice—with children with "well baby" visits. But nonetheless, they are treated in a disease-oriented system. The "stirrups" position and the draping of women on the examining table (to say nothing of the air-conditioning set at a temperature to accommodate the dressed doctor, not the undressed woman) may be efficient for the doctor, but has negative consequences for the patients in terms of their self-image and self-respect—often meeting the doctor first in that position. Indeed, the medical treatment model serves to isolate women, to prevent them from gaining a sense of shared experiences.

In an advanced "postscarcity" age, the major health problems have to do with prevention and with chronic illnesses; for example, heart disorders, cancer, hypertension, diabetes, emphysema, mental illness, et cetera.

Anselm Strauss describes a series of steps necessary to enable those with chronic illnesses (the most rapidly increasing and most expensive to treat) to cope with their illness and the concomitant crises such as:

(1) The ability to read signs that portend a crisis; for example, a diabetic being able to recognize the signs of oncoming sugar shortage or insulin shock, or an epileptic being able to recognize an oncoming convulsion. In a sense, this is a form of self-diagnosis.

(2) The ability to respond to the crisis of the moment. To use the two examples above, the diabetics who carry sugar or candy or insulin, or the epileptics who stuff handerkerchiefs between their teeth just before convlusions. These are, in a sense, forms of self-treatment. An aspect of this self-treatment is to carry it out in a manner which keeps one's symptoms as unobtrusive as possible; for example, emphysema suffers learn to sit down or lean against buildings in such a fashion that they are not mistaken for drunks or loiterers.

(3) The ability to establish and maintain a regimen. The extent to which a person is able to do this depends upon his or her belief in the efficacy of the regimen and the guarantee that important daily activities, either of the patient or of the people around him or her, can continue relatively uninterrupted.

All three of these steps—the ability to read signs that portend a crisis, the ability to respond to the crisis of the moment, the ability to establish and maintain a regimen—are central characteristics of health care in a consumer-centered model. For these steps to be carried out, for the patient indeed to be a producer of his or her own health, he or she must be trained in matters traditionally the prerogative of the professional, must be encouraged to be an active participant in the achievement of the cure, must be "turned on" to doing so, and must be convinced of the efficacy of the undertaking.

In a chronic disease, such as diabetes, where the patient can be relatively symptom free, the maintenance of health requires that the patient participate in the treatment of his or her disease to an unusual degree. Although treatment methods are usually effective, it is necessary for the patient to be a willing, active partner in his or her own treatment.

This is the context in which health education and disease prevention can take place. The focus must be on those efforts which can mobilize the health consumer him or herself. While health professionals have not been unaware of this, for the most part their efforts have been addressed to disease or to health education activities far distant from the reality of the individual's life.

A major breakthrough in this area was made in the 1960's with the introduction of paraprofessionals, or as I prefer to call them, "New Professionals", into health and other human service fields Of course, the major initial impetus for this was the new careers program proposed by Mr. Scheuer. It enabled thousands of community people to provide useful services to the community. Many of the neighborhood health centers continued and extended these activities, as did other programs including family planning. Indeed, in our work at the New Careers Training Laboratory, we have had the opportunity of training thousands of health paraprofessionals directly and through the training of trainers. I was also privileged to be able to organize the new professionals section of the American Public Health Association to represent the interests of these workers.

Unfortunately, the cutbacks of the late 1960's and 1970's decimated many of these programs, although paraprofessionals continue to work effectively in large numbers in a broad array of health programs. They are effective because they are anxious to be of service.

As programs of public service employment develop, and the endemic continuation of high levels of unemployment make their necessity clear, we need to pay special attention to the potentials in the health field, particularly as they relate to health education and disease prevention. An important initiative in this direction has been taken by the National Center for Health Services Research which last spring sponsored a highly useful conference on public service employment and health. The reports of that conference are now being disseminated as "Proceedings by the National Center." In addition, selected papers prepared for the conference are to be disseminated to a wider audience through Social Policy magazine for November–December.

But it is not the new professional alone who is central to a breakthrough in health education. There are a number of other factors. One such aspect is the introduction of basic structural changes, such as controlling cigarette and alcohol advertising, requiring safety belts or air bags in cars, providing better housing, making improvements to reduce the incidence of lead poisoning, and developing and enforcing occupational safety measures.

A second important thrust is to involve patients themselves, both individually and in self-help groups, for, as I stated earlier, experts have noted that the most significant potential for improving people's health is through changes in what they do and do not do for themselves. The patient or consumer can be the key to the development of better health in our society and a much less expensive one than expanding medical facilities and equipment. Patient involvement ranges from the more exotic techniques of biofeedback and transcendental meditation to the medical history the patient provides in the doctor's office. A thorough and accurate history will significantly influence the productivity of the doctor and the health of the patient. Patients further contribute to their own health when they follow the regimen prescribed by the doctor and report reactions promptly and accurately. Included here also might be the role that the doctors can play in assisting patients in self-examination, 1 doctor in Indiana trained over 4,000 patients in doing these exams.

With regard to self-help groups, Smokenders, Weight Watchers, and Alcoholics Anonymous have been found to be most effective in controlling smoking, obesity, and alcoholism; and the nearly 1,200 feminist health centers in the United States, which employ the self-help ethos and treatment mode, are an extremely valuable source of health maintenance. The September–October issue of Social Policy magazine, on whose editorial board I sit, contains a number of important articles on women and health.

Self-help groups have also been developed for those who suffer from acute disorders that persist as well as the acute episodic phase of long-term disorders, such as strokes and heart attacks. Organizations such as Mended Hearts, Masectomy, Inc., the Stroke Club, and Laryngectomy, Inc., help patients adjust to their new situation after an operation, or other highly specific treatment for the acute phase of their illness. The laryngectomy group helps club members perfect speech techniques. Masectomy, Inc., helps patients face the psychic problems associated with breast loss, along with interpersonal marital, and sexual problems, and their fear that the cancer may recur. Stroke Club members help train the patient and the family to communicate through finger pressure. These consumer-initiated services are playing on enormous role in the rehabilitative process, and major health organizations, for example, the American Cancer Society, American Heart Association, are now sponsoring self-help clubs.

There are, however, some major problems that the self-help movement hasn't yet tackled, particularly in the areas of education and prevention. One of these is hypertension, a disorder which is particularly widespread among blacks. In America today there are approximately 19 million people with high blood pressure who remain untreated and are for the most part symptom-free. But if this disorder remains untreated, it can be very dangerous for the kidneys, for the heart, and for the life of the individual. Finding these people and organizing them into self-help groups is not the task of the doctor, although of course in prescribing for them and in evaluating the effect of the prescription, the doctor plays an important role. Equally important perhaps for these individuals, is the development of a weight-reducing and exercise program concomitant with their regular ingestion of the prescribed drug. These are self-activated behaviors most influenced by the patients themselves and by groups assisting them.

We are not suggesting the removal of the professional or the leader. Rather, we would propose new roles in which the professional may be the catalyst, stimulator, orchestrator, manager, and supervisor, who directs skills and knowhow toward the maximum involvement of the consumer, student, client, and patient—not merely for the sake of their participation and all that may mean in emotional terms, but also very specifically to improve the quality of the service, the learning, the health, and so on. The training and managerial skills of the professional will have to be quite different and will have to be focused outward upon the consumers, directed towards methods of involving them and organizing the system so that it will encourage better consumer input.

Here, then, in the use of the paraprofessional and in the direct involving of consumers themselves are two key concepts for major breakthroughs in health education and disease prevention. My detailed remarks on H.R. 8278 are in the contest of these ideas.

In this light, I am supportive of the language in section 1701, for the incorporation of "appropriate health education components into every facet of our society," and the focus on the activities of "the general public in its patterns of daily living." Further, I favor the provision placing responsibility upon the Secretary to make inputs as to health education issues regarding pending legislation (sec. 1702). Conditioning program or project approval on the presence of adequate health education plans is putting teeth behind the words. (sec. 1703). Further bite may be gained by requiring the Secretary to make annual reports to the Congress on the implementation of these provisions.

More specifically, in section 1713(3), among the activities which warrant specific inclusion as types of activities which the Secretary shall fund, should be programs utilizing (a) paraprofessionals, and (b) activities of self-help groups.

Among the criteria for health education centers, section 1713, (B) (ii), should be a community advisory committee and the mandated conduct of demonstrations as to the utilization of paraprofessionals and the role of self-help groups.

In the informational programs, section 1714, there should be provision to assure that they be carried out with awareness of the language and custom pluralism of the people of the United States. The single reference at the end of the long paragraph, section 1714(3), is not sufficient. All of the information activities under the act should be so conducted.

The requirement to assess new aspects of health care, section 1714 (8), should be amended so as to include the activities of consumers in self-help programs.

While it is beyond the immediate scope of this legislation, I want to call to the subcommittee's attention the complicated problems presented for third party payment schemes by the growing role of self-help groups, in general, and self-care in particular. Not only are doctors not always the most efficient providers of particular types of health services, in some instances they may not be the most effective. To require that reimbursement be only for services which are doctor provided or doctor supervised may not be to support the best or most cost-effective services. Further, where laypeople learn to do self-examination or even self-treatment, the payment consequences need to be thought out. More broadly, the tendency of the present payment designs to conduce toward reimbursement for treatment and to constrain away from education and prevention activities mitigates against both quality of service and efficiency. As the Congress considers changes in the present programs, and as it moves toward consideration of national health insurance, these are issues which require careful attention.

H.R. 8278 is an important step forward toward the goal of accessible quality health care for all Americans. While most attention has been directed toward the need for payment schemes, such as national health insurance, and I endorse such efforts and support programs which provide maximum coverage without payment at point of service delivery, intervention, solely in the form of payment schemes, no matter how good they are, is insufficient. We need, at the same time, supply side interventions. H.R. 8278 does this. I hope that the perspective I have presented and the specific recommendations will carry the effort further. Thank you.

Mr. **Rogers.** Thank you very much, Mr. Lynch, for your statement and explaining to us the background of the experience you have had. The committee will go over your suggestions very carefully.

Let me ask, just to get your thinking, how should self-help groups be developed or organized or sponsored?

How would we do it with hypertension, for example, if we wanted to try?

Mr. **Lynch.** I think there have been some experiences with groups like Alcoholics Anonymous, Weight Watchers groups, and I think the same kind of models could be used for hypertension.

In my statement, I referred to hypertension. I think there are 19 million people in this country now who have hypertension and they are walking around undetected.

I think that with the utilization of paraprofessionals as outreach people and people to formulate such groups, that that could happen.

Mr. **Rogers.** Thank you very much.

Dr. Carter.

Mr. **Carter.** I thank the distinguished gentleman for his statement. I have no questions.

Mr. **Rogers.** Mr. Preyer.

Mr. **Preyer.** Thank you, Mr. Lynch. I appreciate your statement.

Does the new career training laboratory with which you are associated itself participate in health education activities and, if so, are there any that you would like to describe to us?

Mr. **Lynch.** We are not involved directly with health education activities. What we have been doing with health institutions is to provide training for the management of that institution to develop new careers programs, how to best effectively utilize paraprofessional and community people in the delivery of health services.

Mr. **Preyer.** Fine, thank you very much.

Mr. **Rogers.** Thank you so much for your presence here today and for your effective testimony. Thank you.

Our next witness is Dr. Lucie S. Kelly, professor of nursing in both the School of Nursing and the School of Public Health, Columbia University, who will be speaking on behalf of the National League of Nursing.

Dr. Kelly, we welcome you to the committee and we are pleased to receive your statement. In fact, your statement will be made part of the record in full at this point.

Dr. **Kelly.** Thank you.

Mr. **Rogers.** You may proceed.

STATEMENT OF LUCIE S. KELLY, R.N., Ph. D., ON BEHALF OF NATIONAL LEAGUE OF NURSING

Dr. **Kelly.** Thank you, Mr. Chairman.

I am Lucie Kelly, professor of nursing at the School of Public Health and the School of Nursing at Columbia University. Prior to that, I was director of the patient education program and acting director of the Office of Consumer Health Education, College of Medicine and Dentistry of New Jersey.

I am representing the National League for Nursing—a coalition of 1,800 nursing education and nursing service agencies and 15,000 individual members—nursing leaders, other health professionals, and consumers—who work together to improve the quality of nursing education and nursing service in the United States.

The National League for Nursing would like to share with you its views on the consumer health education legislation before your subcommittee.

The NLN supports the development of a comprehensive national health education program. The time has come for a national force on a neglected component of our health care delivery system. We believe that the greatest potential for improving the health of the citizens of this country is to teach and motivate people to lead healthy lives. Without special emphasis on preventive care, the national health insurance system will not improve the health status of the country.

The mortality and morbidity data collected for the report of the Task Force on Consumer Education sponsored by the American College of Preventive Medicine and the Fogarty Center of the National Institutes of Health, show a preponderant incidence of preventable causes, generally not of the kind that lend themselves to medical care.

The problems appear to lie primarily in different health habits and lifestyles of individuals, not in the amount of medical care they receive. Documentation on the relationship between death rates, health status, and lifestyle is accumulating at a rapid rate.

Yet national health policy has been slow in responding to the need for prevention care. Of the total current budget for health care in the country, only 2 to 2½ percent goes for preventive measures, and one-half percent for health education.

Mr. Chairman, your proposed legislation would provide the basis for an effective national strategy for health education which the country needs. The NLN supports the concept of the legislation and offers its comments on the following issues:

AUTHORIZATION

A national health education program calls for a major Federal financial investment. The NLN recommends that the program be given adequate authorizations to make consumer health education a national health goal in our country.

ADMINISTRATIVE STRUCTURE

The NLN commends the efforts of the Bureau of Health Education in the Center for Disease Control, which has been responsible for consumer health education in the past. But the need for a national focus on health education requires that the program be placed at the highest decisionmaking level possible in HEW, with the kind of authority status and resources which will make health education a major health goal of the country.

To maximize the potential of Federal health education activities to provide for the exchange of information, and to avoid duplication of effort, the director of the national consumer health education program should be responsible for the coordination of all health education activities sponsored by Federal agencies and departments within HEW.

DEVELOPMENT OF HEALTH EDUCATION CENTERS IN THE PRIVATE SECTOR

NLN recognizes the value of a national center for health education and promotion in the private sector, complementary to a health education center in HEW.

Such a center would be able to solicit funds from the private sector for the development of health education programs. The center would provide a common frame of reference on health education for the many voluntary health agencies and health professional and educational organizations which sponsor health education programs. Although consumer health education is an important function of many of these private sector organizations, it is frequently not their primary purpose and program, and therefore it does not receive program and funding priority. The efforts of individual organizations, coordinated through a national center, will more effectively serve the consumer.

Such a national center for consumer health education has recently been established, based on a design developed by the National Health Council. Since this center is becoming operational, it is possible that no specific Federal authorization for a center will be necessary in the future.

NLN also supports the development of private health education centers at the State and regional level for research and evlauation of projects within the given locale.

I was director of such a program at the Office of Consumer Health Education in New Jersey. I would like to tell you a little bit about it because I think we were a demonstration model which worked quite effectively.

The Office of Consumer Health Education began with a very modest amount of money, about $123,000, from the Hunterton Fund, which is under the control of the College of Medicine and Dentistry of New Jersey. The president of the college, Dr. Stanley Bergen, Jr., is very committed to health education and, therefore, authorized this program under the direction of Anne Somers. In 3 years, OCHE programs have probably reached some 40,000 patients and other consumers as well as hundreds of health professionals who have been trained in health education—all at the cost of about $750,000. The program itself, as it grew, funded eight hospitals in a State network. The hospitals each received a small one-time grant of about $24,000 for 1 year. Each hospital had to meet a number of criteria to make a commitment to continue health education programs after the funding ceased.

During that time the emphasis was one, and continues to be on, not only patient education but consumer health education, with the belief that a hospital is a center where there should be interest in health and health education services which can be provided to the community as well as to the patient. This approach has been very effective. Each of the hospitals has a coordinator of consumer health education who develops and coordinates both in-hospital and community health education programs. There has been a considerable amount of evaluation done, something which has not been done in many programs. Many problems have been worked out through the evaluation of both the process and results of the health education programs.

The in-hospital programs might be those with which you are probably familiar; teaching patients requiring surgery and those with disease conditions such as diabetes, heart conditions, and other long-term illnesses.

The programs in the community are varied. They include one which takes in a whole series of industries in one community, educating the employees on their lunch hour, a rather small program working with handicapped children who are taking swimming lessons, and giving them some health education, working with alcoholics and working with a "golden age" group.

So there is a tremendous variety of activity in the hospital and in the community which has also been evaluated.

I would be happy to tell you more about this.

Mr. ROGERS. May I interrupt you. Do you have reports of the evaluation?

Dr. KELLY. Yes.

Mr. ROGERS. Could you submit those for the record?

Dr. KELLY. I would be glad to do so.

I also have a rather complete report of the OCHE activities in written form so that you might look at the program in general.

Mr. ROGERS. Yes; may we have that for the record?

Without objection, it will be included.

[The following backup material was subsequently submitted to the committee and may be found in the committee's files:]

Experimental Network of Hospital-Based Health Education Programs, Nancy H. Bryant, R.N., M.P.H.

Hospital-Based Health Education: A Functional Approach, Rebecca S. Parkinson, MSPH and Philip W. Morgan.

Summer Student Health Education Project, College of Medicine and Dentistry of New Jersey, Office of Consumer Health Education, Nancy K. Quinn.

Practical Considerations of Evaluating Patient/Consumer Health Education Programs, Nancy H. Bryant, R.N., M.P.H.

The Effects of Health Education in Rehabilitation After Myocardial Infarction, Lawrence Rausch.

Industrial Health Education: A Program That Works, Marguerite Wagner, R.N., B.S., Nancy H. Bryant, R.N., M.P.H., and Ruth B. Bauer, B.A.

VD Hotline: An Evaluation, Nancy H. Bryant, R.N., M.P.H., William Stender, BSN, William Frist, and Anne R. Somers.

Smoke No-More Clinic—Six Month Evaluation, Mary Jane Shu.

Evaluation of "Fit Not Fat" Conference, Richard N. Podell, M.D., M.P.H.

Mass Communications and Health Education, Lucie S. Kelly, R.N., Ph. D.

What $34,000 Has Done for Long Branch, Anne R. Somers and William Vaun, M.D.

Dr. KELLY. The NLN, like OCHE, emphasizes the great need for research and evaluation of health education programs in the private as well as Government centers. There has been relatively little documented evidence of the effectiveness of health education programs which has hampered efforts to fund or reimburse such programs.

Several of the evaluations done by or with OCHE are quite interesting and I will simply mention one that showed very concrete results. It involves not a hospital program per se, but rather a group of physicians who employed a nurse as a health educator for coronary patients. The evaluation that was done studied those patients that were taught in this program as compared to other physicians' patients who were not taught. The study was just completed and showed that three times as many of the parents not taught returned to the hospital, as compared to those who were taught.

There was also a greater decrease in smoking and some weight loss by those taught. The study is continuing with a larger group of patients.

Another study that is rather interesting, emphasizes another facet of health education—information giving. Although it is extremely important, it does not necessarily result in teaching or learning. Learning does require change of behavior. In the industrial settings, mentioned previously, the hospital health education department gave a series of programs on various aspects of health, including one on dental hygiene and another on the risk factors in coronary disease. After a period of time an evaluation was done to see whether any changes in behavior occurred and generally how the programs were received. The most common change in behavior was buying a soft tooth brush rather than a hard one, a not too difficult behavioral change.

The program with the most negative response was one on risk factors in coronary disease. Those who had the most negative response were the men who were actually models of the risk factors. It was much better received by the women who are not nearly so prone to these risks.

Now, there will be some followup on this program, but I think it does indicate that no matter how valuable information is, if there is not a basic change in behavior, you are really not going to accomplish a great deal.

HEALTH EDUCATION PROGRAM REQUIREMENT FOR FEDERALLY FINANCED PROGRAMS

In relation to the requirement for federally financed programs, the NLN supports the proposed requirements that all States receiving medicaid funds and all institutional providers receiving Federal grants or contracts for health services provide health education for the consumers they serve.

Mandating such a service is the only way to assure that health education becomes an integral part of the services being financed by the Federal Government.

MEMBERSHIP ON THE NATIONAL COUNCIL ON HEALTH INFORMATION, EDUCATION, AND PROMOTION

Among the health professions, nursing is the most involved in health education. The largest part of the nursing population—some 578,000—work in hospitals and nursing homes. Traditionally these nurses have provided patient education. In addition, some 54,800 nurses in public health and school nursing and some 20,000 in occupational health nursing have been providing active preventive health education programs.

Today, many nursing practice acts explicitly make health education part of a nurse's function. Nurses have a broad knowledge of health and illness, and their direct continual contact with the consumer in multiple settings make them the likely health professionals to provide health education.

Since nursing plays such a significant role in health education, the NLN believes that your legislation should include nurses in the membership of the Council on Health Information, Education, and Promotion. Nurses who have been actively involved in providing health education could make valuable contributions to the deliberations of the council.

DEVELOPMENT OF HEALTH EDUCATION CIRRICULA FOR THE TRAINING OF HEALTH PROFESSIONALS

The report of the task force on consumer health education points out the lack of qualified individuals to carry out the needed health education programs throughout the country.

NLN strongly supports your legislation's provisions for the development of model curricula for the teaching of health education to health professionals. Model curricula should be designed for continuing education programs as well as for basic programs. Both types of programs should include clinical components.

I had an academic appointment at Rutgers Medical School, and the seminar that I gave to the medical students was one of the few in the country that had any aspect of patient teaching or health education in it, and it was only an 8 hour seminar. In another part of the medical school, OCHE mnaged to get in some clinical health teaching for other medical students. Because of Dr. Berger's commitment there is a continuing attempt to include health education in the medical school's very tight curriculum.

I found the medical students extremely interested. Medical students need the teaching experience because while they have the medical knowledge they can tell, but they do not necessarily teach.

Nursing schools have been teaching some aspects of health education, but their curricula need to be revised to reflect new knowledge in health education including conduct, teaching methodologies, behavioral psychology, and evaluation procedures to measure the effectiveness of health education programs.

PARENT EDUCATION

NLN supports the priorities for health education outlined in the legislation. In addition, NLN believes that parent education should be given priority in the national health education program.

Young parents are a population group that should be made aware of the need for observing good health habits. If parents can practice good health care measures with their children and in turn, impart these habits to their children, the general health status of the country would improve substantially.

One example of an effective parent education project was a Statewide immunization program conducted by the Arkansas League for

Nursing, a constituent organization of NLN. This program showed the tremendous potential for educating parents on the immunization needs of their children. Mrs. Betty Bumpers, honorary chairman of the Arkansas immunization campaign, "Every Child by 74," and now and NLN board member, has cited the vast numbers of families taking part in the program who were unaware of the necessary innoculations for their children.

REIMBURSEMENT FOR HEALTH EDUCATION

To make health education programs an effective component of the health delivery system, there must be third-party reimbursement for funding of such programs. The NLN believes that the Federal Government should take the initiative by making effective patient education programs a legitimate cost item in the medicare and medicaid programs. Many groups in the health insurance industry have begun to voice their commitment to reimbursement before health education. We urge that their commitment also be implemented as soon as possible.

Mr. Chairman, we pay tribute to you and your colleagues for initiating this consumer health education legislation. We believe that the legislation, if enacted into law and effectively administered, could be one of the most significant health actions taken in this country.

The National League for Nursing thanks you for the opportunity to present its views. I will be glad to answer any questions you might have.

Mr. ROGERS. Thank you very much, Dr. Kelly, for a most helpful statement, particularly with respect to the experience you have had in New Jersey with health education.

I think the reports that you have mentioned will be most helpful to the committee.

Now how do you anticipate third party reimbursement for health education should be handled? I can understand that it would be easy in a hospital setting. What about in an individual doctor's office; should the doctor have to prescribe education or should he just be a natural part?

Dr. KELLY. The process that OCHE has been using in the hospitals has avoided having a physician prescribe because we feel that the patient has a right to know, to be taught. When plans are made for a program of patient education, they are cleared with key medical staff and all patients are taught. Those physicians who do not want their patients taught, must write an order that says the patient should not be taught. Most are very reluctant to do this, therefore, patients are taught in an organized program which is one of the keys to a successful health education. Unfortunately, there are very few organized programs; patients are often taught on a hit-or-miss basis.

In the physician's office we again note that it is not necessarily the role of the physician to teach, but rather that he understand the importance of teaching. In some of the offices that we are familiar with, the physician has employed a nurse or health educator just to each, or it is a part of his office nurse's responsibility. Therefore, it is part of the services given. It is part of the billing. Patient counseling and teaching can be as important as physical examination, and it should be documented. Teaching shouldn't be just a matter of handing out a brochure, which is almost totally ineffective. It should be an organized program; and it should be recorded on a patient's chart, stating that there were certain kinds of information covered and the patient understood the information.

I believe that if those kinds of records are kept, they can be written on the chart or the patient record. If these are kept, this should be adequate documentation to show teaching was done and is reimbursable.

By the way, the Blue Cross in New Jersey does reimburse for documented evidence of patient education.

Mr. ROGERS. Now, what about education in the public schools?

Dr. KELLY. There is a great need. Unfortunately, here again it's not been done very well. Sometimes the people teaching are not in tune with the youngsters or with the young people. They don't know what to teach and don't know how to reach the students. This is a perfect area for the school nurse but often she is not given that kind of opportunity; she is made a bandaid dispenser.

I think that with the nurse practitioner role in which the nurse does take on more responsibility, and teaching is a very important part of this, there will be more teaching.

However, I don't think health teaching is a single profession's job. Teachers, too, can be educated in an inservice program so they can apply some of this information on a day-to-day basis in their daily classes. For instance, the teacher's education can include information on how to handle diabetic children. Health teaching need not be something only for nurses to do.

Mr. ROGERS. From your experience, where do you feel that people generally learn about disease—TV, radio?

Dr. KELLY. Yes.

Mr. ROGERS. Magazines, school health systems?

Dr. KELLY. Apparently they learn much from TV, from public media, more than they do from the contacts they have in the health profession. It is really unfortunate, particularly because some of the information is misleading, particularly in terms of the advertising.

You may be familiar with the study done in Detroit on health information that was given in a week of prime television time. Something like 1 percent was related to health, and most of it came from advertising. Some 80 percent of the health information was misleading or totally incorrect. That is where people get their health information.

Mr. ROGERS. Thank you. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Most of our counties throughout the country have public health nurses who visit schools. Do you think they have an important role in teaching health education there, as well as taking part actively in preventive medicine?

Dr. KELLY. Yes; I think so, Dr. Carter. I think there is a very practical problem though, and that is that funds are not very generous for this kind of thing, and the public health nurses who are also the school nurse on visit at schools for only a brief time. They are not able to spend the time with the students or even with the teachers to prepare a program in health education.

I think that teaching is a vital part of their responsibility. But teaching takes time, and it takes planning. I cannot be purely information giving. I cannot be done on a haphazard basis.

Mr. **Carter**. I will agree on that, but I do think they do perform a very important function in their level. I believe that, of course, health education should be a part of every school curriculum; it should start out at the age at which a youngster can assimilate the ideas and principles.

Dr. **Kelly**. We are really interested in starting it with Project Head Start. It doesn't hurt to start at age 2 or 3.

Mr. **Carter**. Yes, ma'am. Thank you for some excellent testimony.

Dr. **Kelly**. Thank you, Dr. Carter.

Mr. **Rogers**. Mr. Preyer.

Mr. **Preyer**. Thank you, Mr. Chairman. Thank you for your testimony.

Several States and private organizations have started publishing cost information for hospitals and physicians, and drugs for public use. Do you support that kind of activity?

Dr. **Kelly**. Of publishing costs of their activities; yes.

Mr. **Preyer**. Yes?

Dr. **Kelly**. I think I have a very strong feeling, and the National League for Nursing does, too, that the public has a right to know.

Mr. **Preyer**. How effective do you think that is as a cost control method? How effective is it in giving people better choices?

Dr. **Kelly**. I am not sure that it is effective in terms of just publishing the information. I think there has to be an educational program along with it.

Teaching people about the services that are available and which might be best for them and where they can get it. I think simply publishing figures is for the more sophisticated members of the public and others need some interpretation.

I happen to think that kind of information is part of health education, too, because how a person seeks health care, and the fact that he may not seek it because he can't afford it or doesn't know where to get it, is as much a part of health care as anything else.

So I believe there is more to it than just publishing figures. I don't have any data that indicates whether it is or isn't effective. That is my opinion.

Mr. **Preyer**. It would seem to me a sensible suggestion on it. Thank you very much.

Mr. **Rogers**. Let me ask a few more questions. How effective would a hospital be as a health education center for the community, in reaching the healthy people, the ones that don't happen to come into the hospital for treatment?

Dr. **Kelly**. One of the first things that is necessary is communication with the many other agencies, in the community which give some form of health education. There is absolutely no point in duplicating effort. That is the first thing that is suggested to the hospital health education coordinators, to reach all of the other groups, or as many as possible that do some form of health teaching and to work cooperatively on some of the activities.

There are often gaps in health education. There are some areas in which there is a great deal of teaching and some in which there is very little. At OCHE, we also found that there are differences between communities. We encouraged our funded hospitals to become regional health education centers after their year of funding. Duplication is then avoided. Every hospital doesn't need every kind of health education program. They may need individual patient education programs, but not health education programs for the community. They can get together and do such things as hypertension teaching or screening or start a self-help club. I am also a firm believer in individuals helping themselves. This is a major point, that the patient help himself.

Many of the hospitals have health fairs, which include a teaching component. All the hospitals also have advisory committees which include members of the community, so it is not just the hospital administrator or the health education coordinator saying what a community needs. It is the community saying, "We need this." There are also advertisements. There is a great deal of public support for consumer health education, and the programs are held at a free, convenient place where people can get to them. Often the events are well advertised.

There has been a tremendous response to the various kinds of programs that have been held with no rejection at all. One of the problems obviously is that there is no reimbursement for consumer health education by Blue Cross or any other third-party payor.

PR value for hospital-based health education program is great and the attitude of the public is very positive toward them.

Mr. **Rogers**. I presume it is difficult to get across the value of proper diet and nutrition, exercise?

Dr. **Kelly**. Yes, that requires a basic change in behavior that isn't easy for people. I refer back to the Standford study in which a variety of media was used to teach the public about the risk factors in coronary disease and it was found that while there was some change in behavior in those who were exposed to the media, the only really meaningful change in behavior was in those who also had a personal contact. This followup is one of the points that was stressed in OCHE. Health education is not just a big lecture but there is the availability of followup. In many cases the health education coordinator in OCHE-funded hospitals has almost an open telephone line and people in the community would call her about specific health problems.

Information giving simply isn't enough because people don't want to change their very, very comfortable habits.

Mr. **Rogers**. Thank you so much for your helpful testimony.

Dr. Paul Elwood is to be here, but his plane has been delayed; he is on his way, and we will try to accommodate him this afternoon at 2:30.

Have we a room yet?

Members will be advised just as soon as we get that number.

So the committee will stand adjourned until 2:30 this afternoon.

[Whereupon, at 11:25 a.m., the subcommittee recessed to reconvene at 2:30 p.m. the same day.]

AFTER RECESS

[The subcommittee reconvened at 2:30 p.m., Hon. Richardson Preyer presiding.]

Mr. **Preyer**. The subcommittee will resume.

We are delighted to have Dr. Paul Elwood with Interstudy Co.; is that the name?

Dr. **Elwood.** Just Interstudy.

Mr. **Preyer.** Interstudy.

Dr. Elwood is well known to this committee, and it is always a pleasure to hear from you. You always contribute a great deal.

I am sorry you had difficulty with the weather coming down, but we will proceed in any way that you would like.

STATEMENT OF PAUL ELWOOD, M.D., INTERSTUDY, MINNEAPOLIS, MINN.

Dr. **Elwood.** I can tell you what is going on in Minnesota is bound to get to Washington before the week is out.

Mr. **Carter.** What is going on up there?

Dr. **Elwood.** We had weather in the 70's last week and set all sorts of world records. I think we set a world record for the rapidity with which the temperature dropped, storms and snow all at the same time.

Many of us who shifted from being professional patient treating doctors to being amateur health policy doctors have concluded that the United States is rapidly moving to the point where it is spending and doing so much in the way of conventional medical care that we are endangering our own physical health and certainly endangering our country's economic health.

Health care is gobbling up more and more of the GNP; within the last year the proportion of GNP going to health has jumped from 7.7 percent to 8.3 percent. This is a rise in 1 year that is comparable to that that occurred in the previous 5 years, at the same time frustratingly uncertain about what to do when it comes to devising some suitable role for the Government to help us stay healthy and to stay out of the hands of the increasingly expensive medical care system.

I thought this dilemma was nicely expressed last week at the Institute of Medicine meeting by Harvard economics professor, Thomas Shilling. I thought I would read to you a little bit from what he had to say.

Incidentally, I am a terrible reader. When I was in the third grade at Glenview School in Oakland, Calif., I was the best of the third reading group, but I could never have made it in the second reading group or the first reading group; so you are going to be subjected to my reading.

Mr. **Carter.** Do you happen to be left handed?

Dr. **Elwood.** No, right handed.

Mr. **Carter.** I thought, if you were left handed, you might be dyslectic, which is certainly no indication that your I.Q. is not quite high.

Dr. **Elwood.** Well, it might be that it is. Certainly, I think then it was an indication my vision was bad.

There are three things to be said about the Government's role and responsibility from keeping us from abusing our body and ruining our health.

The first is that most of us are not very healthy and it is our own fault, but an effective Government might do wonders for our health and save money in the process.

The second is that most of us don't trust the Government to tell us what to eat and drink and what games to play and when to go to bed and how much breakfast to eat and how much light to read by and what kind of shoes to wear and whether or not to discontinue deodorants.

The third is that when our own Government and possibly any democratic government tries to intervene massively in the way we take care of ourselves, especially by prohibiting activities that it thinks are not good for us, it does a pretty poor job.

The road to Hell was paved with good intentions, like liquor and drugs and pornography and even the Army can't control hair styles any more. I will bet you that a law against bare feet on the sidewalks would undoubtedly cause more people to take their shoes off than to put them on.

Still it is worth pondering that smoking and overweight typify what is the matter with us and a lot of us are unable to do much about it individually and can't find a Government strategy to help us.

The question arises whether some day the Government preferably, that means the National Government in Washington, might want to declare war on overweight or smoking the way Government's dollar war on poverty and cancer and racism.

But here is where the issues do become more philosophical and constitutional.

National health insurance is a mundane bit of household finance compared to the right to smoke and the right not to be smoked at or the right to sleep late or to eat bacon and eggs for breakfast.

I think that is the question that faces this committee. How far should you go now with the problem which I predict this committee will come to find is the most time consuming and most vexing that it will have to face over the next 10 years.

Most of what the committee has to consider in the way of health education and prevention proposals are exceedingly modest, in both cost and intent. Some of the committee bill, in my opinion, goes too far in the direction of coercion, given what we know about the consumer use of health information that is supplied to them at Government expense and Government insistence at the present time.

Parts of that bill that I find somewhat objectionable are those portions which require medicaid to provide health education services and which force States to provide various kinds of comparative information on doctors and insurance policies and the risk of losing some of their medicaid payments. Those may well be good ideas but I am not at all certain we know how to do it at the present time to go that far at the present time.

None of the legislative proposals that you have before you match the problem because the State of our knowledge on how to live a healthy life and how to diagnose and treat our own illnesses and how to make the best possible use of doctors and hospitals and drugs, our own knowledge doesn't simply match that problem at the present time.

So I would suggest that you modify the existing proposals sufficiently that they allow the committee to come back to this subject on health education and prevention in each of the next 3 or 4 years, with the idea that the answers to congressionally identified questions will allow the United States to attack the problem with increasing sophistication of purposes.

What I am suggesting is that the committee does as they have done in the planning legislation where they identify some very specific questions they are bothered about and that prohibit them from writing very all-encompassing legislation at this time that they identify those problems and bring the people who are attempting to answer them back before the committee over the next several years.

For starters, let me try to spell out a few of the questions I feel we need to know more and can find out about the next 1 to 4 years.

The first question is this: What is our current knowledge of the impact of nonmedical card factors on health, including the important gaps in that knowledge?

Now, a tentative list of study areas might sound something like this: Would we know about the influence of health hazards in the environment, like air and water pollution, electronic pollution, noise, poor automobile and highway design—and we all talk about these things and say that they are great hazards, but it is remarkable how little we have done to really sort them out and to identify the magnitude of hazards that they are or if they are.

We also now I think should look further into what you might call cultural and societal factors that contribute to differences in health status between various socioeconomic groups. The scale and choice of living settlement.

Housing, nutrition, education, all of these things may well contribute more toward individual's health than the care or medical care they are receiving.

What about individual behavioral factors, how important are they exercised over people jogging around? Does it make any difference to our health or doesn't it?

Smoking, alcohol, and drugs.

I think that is the first study that I would suggest that the committee commission to have undertaken.

The Institute of Medicine has proposed that such a study be undertaken and that isn't a bad place to do it. Given the membership of that particular organization, I suspect that they could gather together the kind of expert knowledge that would be necessary to do a job there.

The second area that I think we ought to look more into is how effectively we can diagnose and treat our own health problems? How much in the way of self-treatment in the presence of illness can we engage in? I am thinking of the kind of thing like Dr. Donald Eswiler of the St. Louis Park Medical Center is doing with diabetes, when he has a new patient with diabetes, he spends as much time teaching that patient how to live with his disease, how to give himself shots, how to eat properly, how to check himself to see whether or not urine sugar is too high.

Mr. Carter. If you will permit, that really is health education; is it not?

Dr. Elwood. That's right.

Mr. Carter. And it is performed by a health professional?

Dr. Elwood. Yes.

Mr. Carter. Certainly it is great.

Dr. ELWOOD. Yes, sir. It is a physician conveying his knowledge to an individual so that that individual can manage his own health problem.

Mr. CARTER. In that sense it is preventive, too, in nature?

Dr. ELWOOD. You bet. It keeps the patient out of the hospital with diabetic coma and problems of that sort.

The secondary of self-treatment that I think is of interest——

Mr. CARTER. On that, did you ever hear the statement he who doctors himself has a fool for a patient?

Dr. ELWOOD. One witness that you might want to get in here to testify that notion a little bit is Dr. Keith Zaniard. I don't know whether you have heard about him?

Mr. CARTER. Yes, sir.

Dr. ELWOOD. At Georgetown. And he has been conducting a little program to teach people how to diagnose and treat themselves.

Mr. CARTER. Oh, my goodness.

Dr. ELWOOD. He passed out a little what he calls a space age medical kit which is a kit similar to, I gather, what people took to the Moon in case they got sick in the absence of a physician.

You understand, I am suggesting these as areas for you to look into for research to be done on, not as necessarily the way to go in the health education.

Mr. CARTER. Haven't we had that over the years? We have had self-medication and medication by patients. That is the way we found some medicines like digitalis, for instance, from fox blood, and atropine, isn't that quite true, from the plant?

That is the way they have evolved. We have had self-medication over the years. And I don't know it is necessarily good although it has helped in some areas in discovering some of our medicines.

Dr. ELWOOD. One possible value of the thing is that if you know more about yourself and what you can and can't do to yourself, it helps you to know really when you should go for help.

Mr. CARTER. How much fox blood, you should say.

Dr. ELWOOD. I don't remember diagnosing that you are in cardiac failure and going to the medicine closet and getting your own digitalis.

But, a third area of self-treatment that I think is especially interesting and would be worth the committee commissioning further studies into, and this is the whole consumer self-help movement, where one individual who has had a particular health problem helps another individual that has got that problem, and I think this is particularly effective in areas where the problem is largely or partially emotional.

Alcoholics Anonymous is an outstanding example that I think most of these other kinds of buddy system health care programs are patterned after.

With many kinds of disfiguring surgery there are clubs that have been established where people who have undergone—women who have undergone a masectomy, for instance, will help other women to accept the idea of having had a breast removed.

Or where individuals who have had their vocal cords out teach other individuals how to communicate or where experienced parents assist new parents.

This is a movement that is growing in scale in the country and which may be a very, very important device for health education.

A third area that I think it would be well for the committee to look into is to evaluate how the changes in provider incentives have evolved in things like HMO and alternative delivery systems, whether or not those things have indeed produced any increase in health education and prevention.

Advocates of those things came down here and said, if you have the doctor in a position where he is responsible for the cost of the patient's illness, that you will make him much more conscious of the need to keep people well.

Is it working out that way? Are there any actual gains in health status as a result of any preventive measures that these organizations have undertaken?

Among the more than 100 new HMO's there have been a variety of rather systematic approaches to helping their members to stay healthy or to detect disease early.

Automated medical screening, for instance, has probably seen its greatest refinement in these kinds of organizations. A number of them have free health training programs, a number of them are using nonprofessionals to a greater extent in health education because they can spend more time with the patient.

A fourth area that I would suggest that we look at, and that is, does giving information to consumers on the quality and value of medical care influence their selection of sources of health care, and does it have any influence on the behavior of health profesionals who are described either positively or critically in these reports?

Here I have in mind the kind of thing that was done in Pennsylvania where an insurance commissioner published a Consumers' Guide to Hospitals and another Consumers' Guide to Insurance and another Consumers' Guide to How To Select a Surgeon.

I understand that Bob McGarrah is going to be appearing before the committee to describe his experience in preparing a Physicians' Guide to Physicians in Prince Georges County.

Our group has been hired by a large health and welfare fund to go out and evaluate sources of medical care for them and to bring back to them an evaluation of HMO's as a possible place for them to get care.

That is a very interesting position to be put in, if you are a doctor.

These people came to me and said, "We want our members to only go to places for medical care that would be good enough for you to go to yourself or to take your family to as a physician."

And being put in that position, for in this instance, almost a million people is a very, very difficult position to be put in and one that we are not at all certain how to do and I suspect that there are a number of insurances of this type where we have tried to do this.

We ought to know whether or not we are effective before proceeding any further in pushing this sort of idea.

A fifth area that I would suggest that the committee undertake a piece of research is what methods that Canada and other countries are employing to shift their emphasis from health care to healthy life style?

I don't know whether the committee has had brought to its attention the monograph and white paper that was recently published by Mark Lalonde, who is Minister of Health and Welfare for Canada, called a New Perspective on Health of Canadians, but, the thrust of Mr. Lalonde's study, I suspect, motivated somewhat by a concern over the rising cost of medical care in Canada—Canada's rate of medical inflation is more rapid than ours.

But he concludes that improvements in the environment and improvements in health education and prevention probably have more impact on Canadian's health and perhaps the rapid further expansion of medical care.

Whether this country, whether Canada and other countries that have taken that point of view will come up with some suggestions that are useful to us is something that I believe we ought to learn about.

These are just a little series of the kinds of questions I think that anyone looking at the health scene is worried about and we are all, I believe, uncomfortable that we have so many answers to such important questions.

In order to get the answers to questions like these and others the committee might identify, I would suggest that you might want to increase the tempo of health education and preventive activity both in and out of the Government, and I would suggest that you assemble into one piece of legislation bits and pieces contained in the several pieces of legislation before the committee.

Three points. First, to stimulate the private sector's health education activities, and facilitating the startup of the private national center for health education as you proposed, Mr. Carter, and which is contained, too, in the Senate health education bill.

This center had its origins in a study that the National Health Council undertook of the state of health education in the country. They concluded that there was a need in the private sector for a focal point to undertake development of health education, and I understand that on Thursday, an umber of members or representatives of that group will be appearing before the committee.

Second, I would suggest that you create a number of demonstrations and sites for R. & D., and proceed with the authorization of several diversified health education research and development centers as proposed in the committee bill H.R. 8278.

And third, that you pull together the diverse forces within the Government, and you establish a site for managing research and development and demonstration within HEW for health education such as that suggested by Mr. Hastings and Mr. Cohen in their health education administration idea, H.R. 3205; or perhaps more ambitiously, create a National Institute for Health Education and Prevention as proposed by Mr. Rogers and other committee members in H.R. 8278.

So in summary, we are suggesting that the committee is just beginning a huge complex and basic research for answers to questions that we have few answers for at the present time.

I think that the committee could be most helpful to the country at this time by identifying some of the questions in very specific terms that it would be well for us to try to answer, and then that through the creation of a national center on the outside a series of research and development centers, and by the creation within the Government of a focal point for health education, that we get on with the job of trying to get answers, and then as these answers are developed, they be brought back here to the committee for further refinement of the whole process of health education and prevention.

That concludes my statement, Mr. Preyer and Mr. Carter.

Mr. **Preyer.** Thank you very much. Dr. Carter?

Mr. **Carter.** Thank you, Mr. Chairman.

It is always good to have a very knowledgeable man like Dr. Elwood here to testify, and he's done it in an excellent manner, as I see it.

I like the doctor's completely clear presentation, and he covered it rather comprehensively.

We were speaking of physicians, awhile ago, and I believe I read just a day or so ago, I had read something similar to this previously, any physician who never has been sick can't be a good physician.

I believe there is something to that. At least, he knows the illness which he has better than any other.

I am certainly alarmed that the cost of health has gone up so much, and there are many factors in there, including our wages, the costs of physicians; and malpractice insurance, of course, is another rather large element. It is estimated that in some areas it is going to add $3.50 to each patient's visit. I believe that is correct, is it not?

Dr. **Elwood.** I heard estimates even higher than that.

Mr. **Carter.** I read an an article, I believe in the Record today, indicating that that is true in some areas of our country.

What about health studies in our schools, Doctor; are we teaching hygiene now and health in our schools?

Dr. **Elwood.** I guess that is another area I should have identified as a place we ought to be looking, and that is where the best places are to give stress to health education. Is it the worksite, is it the school?

Mr. **Carter.** It may be neglected now. When I came up, it was taught, we had health as a subject at least for a few years in school. Did you not have?

Dr. **Elwood.** Yes; I was just thinking about where I learned? I think I learned more first aid in the Boy Scouts than I learned in medical school. I really do.

When I was going to medical school, I don't remember even learning artificial respiration, and you certainly learn that in the Boy Scouts. So there certainly are a lot of places where we learn how to take care of ourselves and learn how to help other people that are in trouble.

Mr. **Carter.** If you worked very long, of course, in an emergency room in a general hospital——

Dr. **Elwood.** Then you learn it.

Mr. **Carter.** Then you get the gamut of the whole thing?

Dr. **Elwood.** Yes.

Mr. **Carter.** If you were in an infantry regiment in combat, and you lose a third of your regiment, you sure as heck very quickly learn what first aid actually means.

Dr. **Elwood.** That's right.

Mr. **Carter.** And aid of all sorts. Of course, you don't get that in medical school.

I was interested in your talking about the physician who was treating the diabetic. About 1964 or before, probably 1962, we came out with different tablets, and the names now escape me, as they often do when I want them right at my fingertips, to be used for diabetics. It was difficult to convince patients to use them, after I learned personally from usage that these tablets really did not have the benefit they were supposed to have. I find that this information has not been disseminated widely even though we know now that there are increased numbers of heart attacks among those who use tablets. There is resistance by patients because they don't like insulin, which, with diabetes, is the only treatment which is satisfactory if the blood sugar can't be controlled.

But in this case we failed to inform our people. Actually, we made a disastrous mistake. These tablets were developed by several of our large companies. One of them comes back to me now, it was Ornaze, that was the first one, I believe, and the other one D. & B., put out by another company. But we should ge this information out to our people, and we should have some method of doing it.

How do you suggest it?

Dr. **Elwood.** Well, you know, one aspect of health education that needs to occur is the kind of a change in psychology that we as physicians have.

I think we sometimes assume that it is the patient's responsibility to take a pill and to come back and see us when he should come and see us, and so forth.

And in this instance and in reality I believe that is our responsibility. I think the good medical care system ought to be like good highways; people ought to be able to make mistakes on them and still survive.

In the case of the effectiveness of various drugs, I suspect that long periods of time elapse without us necessarily knowing that a drug is effective or has adverse side effects because we haven't built into our medical care system a followup system that determines on a conscientious basis whether or not the patient is taking his pills that are supposed to lower his blood pressure or blood sugar, and that gives us a warning that things aren't working out well and at the same time gives the patient a warning.

I think all of this is mixed up in the business of doing a good job of health education, in reality knowing what happens to our patients after they leave the doctor's office.

Mr. **Carter.** Of course, as I see it, it takes a conscientious and dedicated physician to do this. Really, this is the only type of individual who should become a physician in the first place.

Now, it is rather difficult for you to control whether this diabetic youngster takes his injections or not, inasmuch as you impress upon the parents and the patient the necessity of this being done.

Sometimes because injections are painful, and I have had this happen, children tell their parents they have taken it, and the parents have a willingness to believe it. As a result, you often get a child in diabetic coma, even though you educated him about the need for injections.

Certainly, I believe in this education process, and I think the physician who takes so much time with the diabetic is doing an excellent job of education. I certainly think——

Dr. **Elwood.** He has done another thing to get at this psychological problem that you refer to. He set up a summer camp for diabetic kids, I guess there are a number of these around the country now, so that kids who have learned how to take their insulin, play and are colleagues of youngsters that hadn't, and so that you kind of, I guess, acculturate them to the idea that it is OK to take that painful shot and other kids are doing it. I think your illustration illustrates how very, very difficult it is to carry out this business of health education.

Mr. **Carter.** It isn't pain so much, it's the fear of pain. It isn't very painful, as I see it.

You would suggest that in our health studies in schools that we include some first aid?

Dr. **Elwood.** Yes.

Mr. **Carter.** I would think so.

Dr. **Elwood.** I am hesitating here because I feel rather naive about what the real content of health education in schools should be.

Mr. **Carter.** What about our public health nurses and physicians, how do you see their role expanded in this, in which direction?

Dr. **Elwood.** Well, we have got to somehow come to realize how important it is. A friend of mine is a physician who is very, very interested in health education, who is working in an HMO and who has developed a series of health education programs for his patients and for the other patients being seen there, has found that only a small proportion of the physicians in the ground refer patients to him for health education activities even though they are free.

Mr. **Carter.** Well?

Dr. **Elwood.** I suspect that health education isn't given sufficient emphasis in medical school and that we aren't always taught how important it is to do this so I feel very strongly about it.

Mr. **Carter.** In most cases, if they had had health education, they wouldn't be a patient, would they, in many cases?

Dr. **Elwood.** Yes; and I am here talking about the desirability of having physicians and nurses and other healthworkers recognize health education as a very important component of medical care, just as important as that shot or that pill or that operation.

Mr. **Carter.** Health education itself is a form of preventive medicine, is it not?

Dr. **Elwood.** Yes.

Mr. **Carter.** Of course, over the years we have had health departments throughout our country and public health officers and public health nurses who take care of our immuniations and in some cases do some educating of our population. Do you see their role expanded in this or not?

Dr. **Elwood.** I don't know. I think that that has been a two-edged sword, at least in my medical school, and I hate to keep referring to personal anecdotes, but maybe it's helpful in this circumstance.

Public health was kind of stigmatized, and I suspect that health education, if it was lumped in with it, tended to get stigmatized in the same bargain.

Mr. **Carter.** How was public health stigmatized?

Dr. **Elwood.** It was just part of the kind of the culture of the school that that was kind of Government medicine and a place where you weren't a real doctor.

Mr. **Carter.** Well, now, most of these health officers are or have been physicians.

Dr. Elwood. I understand that. I am just describing to you what the mood is in some schools, and I am just wondering whether it is desirable to further fragment and separate the functions of health education from the rest of medical care.

Mr. **Carter.** Let's look at the results.

All right, we have practically obliterated typhoid through efforts of these people, haven't we, our stigmatized public health officials? They were preeminent in doing this, were they not?

Dr. **Elwood.** You understand I am referring to one well-controlled medical student, and he doesn't hear so——

Mr. **Carter.** Go right ahead.

Dr. **Elwood.** I don't want to call them stigmatized.

Mr. **Carter.** But then, of course, they played an important part in almost obliterating polio and advancing the programs and seeing that our youngsters were immunized for tuberculosis. They played a great part in that.

I don't want to stigmatize those people; I don't think they should be. I think that their role has been downplayed when actually their accomplishments have been tremendous.

Right now as a result of their innoculation over the years, we have almost banished smallpox from the face of the Earth. We still have it in Bangladesh and India, a little in that area, and also in Ethiopia, but otherwise we have no smallpox.

So there are many, many things that go into this, and certainly I think that public health has played a role. However, I regret that I have seen immunizations of our youngsters take a downward trend. This is not good.

I trust you will excuse me for taking a little more time than I should, my friend, but of course, there are one or two other things.

You talk about research centers, and I think this idea is very necessary. I think they could very well be coupled with some of the other centers which we have.

Actually, according to our present legislation, we are going to have diabetes centers throughout our country, and I assisted in the formation of that bill.

We are going to have arthritis centers, research centers, and also centers for screening. And we already have cancer centers.

Should we have all of them separately, or should we have them integrated in a center which covers the four different things: Education, diabetes, arthritis, and cancer?

Dr. **Elwood.** Well, I think it would be wise to integrate them as much as possible, and the reason for suggesting that within the Federal Government there be created an administrative focus for health education activities, would be to take maximum advantage of the chances for these things to collaborate. I have had the experience of operating against two different Goverment-sponsored centers, one on ribotation medicine; after that, one for health services research. I think that the center idea is a good idea.

It permits a group of people to concentrate all of their energies on one or several problems and to work together as a team through the years, and I found that that is a vastly superior way to move things along than every year going out and searching for more grants and becoming more effective as a grantsman.

So the center idea is a very attractive one, and one only has to look at the kind of competition there has been within the last few years over some of these center programs to know how important they have become to places that engage in research and education.

Mr. CARTER. Just one other question; that is, how do you see involvement of paramedical personnel in this educational scheme, or say, matters of public health and so on?

Dr. ELWOOD. Well, I see them as very, very important.

Mr. CARTER. Yes, sir.

Dr. ELWOOD. There has been very interesting work done in the Los Angeles Children's Hospital recently on who it is that can most effectively communicate with patients and on health matters, and as it turns out, it is a variety of people for a variety of circumstances.

I think we ought to do everything we can to encourage a variety of professions' involvement in health education activities.

Mr. CARTER. I see. Thank you very much. It's been interesting.

Mr. ELWOOD. Thank you.

Mr. CARTER. It's been interesting to converse with you.

Mr. PREYER. I thank you, too, Dr. Carter.

Those were good questions. I certainly like your approach. I don't think it has as much political sex appeal to say let's find the answers. It's a whole lot better on the stump to say we know the answers and this is what we are going to do for you.

But I think that approach has caused us to do so many wrong things that it is time to approach it differently.

Well, you mentioned the question, for example, of whether publication, publishing of information about consumers, of costs to the consumer, hospital costs and doctors' costs, and so forth, whether that has any effect.

I think most of us now have to judge on our instincts about that. My instinct is that it would have no effect, but I am probably totally wrong.

We certainly do need some answers that go on something more than that. I think you have given us some good suggestions.

Dr. ELWOOD. I think it is terribly important that you spell out the questions you want answered.

Lately, I have noticed more pieces of legislation from this committee and other committees, where it asks the Secretary of HEW to come back with a report on what is going on in the Government and several other rather general questions, and those reports are often years in the creation and I suspect they don't have much impact, and I think that by spelling out just exactly what is troubling the committee and what things they intuitively feel we don't know about these problems, that when the answers are in that it will have a great deal more impact on subsequent legislation that the committee writes and hopefully on the health of the country.

Mr. Preyer. Sometimes some of those reports, I am afraid, are ways of resolving unresolvable questions in conferences where you can't get agreement and you have to get a bill out, you make a study of it.

Dr. Elwood. Call for some research.

Mr. Preyer. Yes. But I agree, I think some of those probably aren't as effective as they should be.

Let us ask our learned staff counsel here——

Dr. Carter also refers to learned counsel—if he would like to ask Dr. Elwood a few questions.

I will put him on his guard that I am going to have to leave in about 10 minutes whether you finish your questioning or not.

Dr. Hyde. Just a couple of thoughts:

First, we have already heard, and will hear a great deal more, to the effect that health education should be covered in national health insurance.

Testimony has been given by the Society of Public Health Educators and others, to this effect.

Have you given any thought as to how health education should be reimbursed, if at all, in insurance programs?

Dr. Elwood. I think the dilemma on this one is very much like the dilemma we ran into with the HMO Act. We specified in that that the HMO should provide health education activities, then when it came down to what is it, we found it very, very difficult to spell it out because I suspect it is a whole series of interactions and even things like a quality assurance system that looks at what kind of results you get, and for that reason I think I would be hesitant at this time to give lip service to health education by saying you have got to do it because, if you say you have got to do it, then somebody had to write some regulation as to what it is.

And given the present state of the art, I suspect that that might have the effect of locking us into primitive approaches to getting at the problem.

I would much rather deal with this one through incentives than I would through spelling it out as a benefit.

Dr. Hyde. I have never been able to envision how you would define a health education benefit coverable under an insurance program.

Dr. Elwood. It is likely to become things like people ought to have annual physical examination. You know how a growing number of people in the field of preventive medicine in public health feel. I know of one top person in the field who started a club that he had the motto of the club: "Let's Stamp Out the Annual Physical Examination;" it's a very costly exercise that may or may not turn up treatable illness, and I think that is one of the hazards of prematurely specifying prevention as an entitlement under a national health insurance policy.

Mr. Carter. Do you agree with that statement: Stamp Out——

Dr. Elwood. The annual physical examination?

Mr. Carter. Yes, sir.

Dr. Elwood. Well, I feel that there are certain selective tests that can be done on people at various ages based on their sex and their living habits that are valuable done on a periodic and regular basis. I think the idea of going and having a very elaborate examination once a year probably isn't worth it.

Mr. CARTER. Does that apply to all age groups and both sexes?

Dr. ELWOOD. Its value probably increases some as we grow older, but again, I would say that the important thing is to be very, very selective about what tests are administered.

Mr. CARTER. What about paps smears?

Dr. ELWOOD. That is a good example of a test that may be cost-effective when administered.

Mr. CARTER. May be?

Dr. ELWOOD. When administered to women of certain ages.

Mr. CARTER. Would you say, may be cost effective?

Dr. ELWOOD. You are trapping me in an area that I am really not knowledgable enough about.

I think it's cost effective when administered.

Mr. CARTER. I will agree on that, it is cost effective. It's very necessary.

Dr. ELWOOD. But don't ask me at what age it becomes most effective.

Mr. CARTER. I won't say anything much except on studies, as my distinguished chairman said, one way of getting rid of certain legislation is to appoint a study group and study it to death. The second thing is the number of pamphlets, the books that cross one of our desks in a day is just unimaginable. I mean it can amount to veritable feet of books and pamphlets. As someone said, if I were to read, let alone, answer all these pamphlets, my goodness, I wouldn't have any time for any other business; in fact, I wouldn't have time enough to read all of them. But I guess we must be selective in our reading.

Anyway, Mr. Chairman, I yield back. I am sorry I interrupted and it's been very nice talking to you.

Dr. ELWOOD. I think I certainly agree with that, but the dilemma is illustrative of this. Here we are having a first hearing on health education and we have 8 or 10 people in the audience and two Congressmen here and a country to the north of us has regarded apparently the program of health education of keeping people well as a sufficiently important problem for it to be one of the principles if not the principal objective of the Minister of Health and Welfare of that country.

Mr. CARTER. I must agree with that.

Dr. ELWOOD. So we have this dilemma.

Mr. CARTER. I think it's extremely important.

Dr. ELWOOD. Of how to sort these things out and what is important and what isn't.

I came down here today, because I think this one is very, very important.

Mr. CARTER. I agree with you.

Dr. ELWOOD. You know undertaking the studies and one way in which the center notion can fit together with the study notion, is that one of the best ways to kind of launch these centers and to get them started in the areas that are important is for you to define a series of questions that you want them to begin by answering, and many of the other center programs they have been rather vaguely described, you be a center that works on rehabilitation or on health services research and the center sets its own priorities and those priorities may not help you one bit in doing your work. So you can kind of put the two things together answering some questions, some of which you may not have time and maybe not be worth reading, but in others I suspect you will launch very valuable enterprises that will be worthwhile.

Mr. **Carter**. Thank you, Mr. Chairman.

Mr. **Preyer**. You may proceed.

Do you have another question you want to ask?

Dr. **Hyde**. Well, I am curious about one thing. One of the requirements of H.R. 8278 that hasn't surfaced yet in the hearing is that the Food and Drug Administration by regulation require that prescription drugs sold to a patient have some information with the drug when it's sold for the use of the patient; a package insert for the patient in addition to the one for the physician covering such things as how to store the drug, what kind of side effect one might expect from it, and its names.

I wonder if you would have any thought as to whether this would be a useful addition or is dangerous?

Dr. **Elwood**. I thought that was kind of a good idea. I didn't know whether this was the right place for that or it belonged in a piece of legislation that dealt with health education in general even.

This is a very critical health education device that you have described. But most of us going to our medicine closet which we knew whether those drugs were still effective, how we should store them and in many instances what prescription number 89873Y, even means.

So I think it is a good idea. I wonder if this is the right place for it.

Dr. **Hyde**. It's hard to think of another place handy.

Did you have thoughts as to whether it should be done with this legislation that hasn't been included in any of the proposals?

Dr. **Elwood**. I gues I don't know enough about the structure of your calendar and when you principally concentrate on food and drug administration matters to answer that question.

Dr. **Hyde**. Thank you.

Mr. **Preyer**. Dr. Hyde is very good on asking specific questions.

I hope he will help us to formulate answers.

We certainly thank you for being here, Dr. Elwood, particularly with the problems you had getting here.

You would have had a little more encouraging reception this morning when we did have a better turnout.

It's hard to stir up much interest in afternoon sessions around here with conferences going on, which is where our chairman is this afternoon, an energy conference, with the Israel Parliamentarians here, the rural caucus tax reform meeting, the tobacco associates' meeting. I happen to have three I am supposed to be at this afternoon. They break up the afternoons, but I am glad we have got your testimony down where we can have it widely disseminated.

We will adjourn until 10 o'clock tomorrow, at a room unknown at this time.

[Whereupon, at 3:40 p.m., the subcommittee adjourned to reconvene at 10 a.m., on Tuesday, November 11, 1975.]

NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

TUESDAY, NOVEMBER 11, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2218, Rayburn Office Building, Hon. Andrew Maguire, presiding (Hon. Paul G. Rogers, chairman).

Mr. Maguire. The subcommittee will come to order.

Our first witness today is Robert McGarrah, Jr., accompanied by Dr. George Pauk and Miss Sallie Adams. Would you come to the table, please.

STATEMENTS OF ROBERT E. McGARRAH, JR., WASHINGTON, D.C.; SALLIE ADAMS, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP; AND GEORGE L. PAUK, M.D., POTOMAC, MD.

Mr. McGarrah. Mr. Chairman, members of the committee, I am Robert E. McGarrah, Jr. From August 1972 until May 1975 I was staff attorney for health care delivery with Public Citizens' Health Research Group in Washington, D.C. Presently, I am health specialist attorney for the American Federation of State, County & Municipal Employees, AFL–CIO, but I appear here today as a private citizen.

LACK OF CONSUMER INFORMATION OR PHYSICIANS

There are no national statistics that describe the amount of time, money and frustration spent each year by Americans searching for doctors who meet their needs. The question, "How can I find a good doctor?" is common to every one of us. And with the average American now making three office visits each year to the doctor (1), and with national health expenditures for fiscal year 1975 estimated at $118.4 billion (2), the problem of locating a good doctor takes on critical dimensions.

The available sources of information on individual doctors are sketchy at best, and in some cases are so inaccurate they are dangerous. Most common are the word-of-mouth reputation descriptions one gets from friends and neighbors. While this is hardly an entirely reliable method, even worse is the telephone book's yellow pages. At least two surveys, in New York City and Washington, D.C., have shown that as many as 15 percent of the "physicians" listed in the yellow pages are either not licensed at all or are deceased (3).

Unfortunately, the medical profession itself has provided no adequate solutions to the problem. Most county medical societies offer a medical referral bureau service. The service consists of a telephone answering facility that gives callers the names, addresses, and telephone numbers from a serial listing of usually no more than three doctors practicing the specialty sought by the caller.

More complete, but less accessible and more complicated, is the three-volume American Medical Directory, published by the American Medical Association. It costs $110 and lists names, addresses, and codes describing a physician's medical school, specialty, medical society and hospital affiliations. A similar directory is published by Marquis, Who's Who, the Directory of Medical Specialists, is also a three-volume publication. Both of these are very difficult to use and are inaccessible. They are often only in public libraries and sometimes not even there.

None of the available sources, however, answers basic consumer questions about doctors: What are the office hours? How much does it cost? Does the doctor accept medicare and medicaid? What hospitals does the doctor use?

CONSUMER DIRECTORIES

Fortunately, for some consumers, there have been some encouraging innovations in the past 3 years. First, came the Shopper's Guides" issued by former Pennsylvania Insurance Commissioner Herbert Denenberg. Among the "guides" issued were ones on dentists, life and health insurance—all of them presenting concise information and questions for consumers to use when they shop for health care or insurance.

Since 1974, however, consumers from Massachusetts to Hawaii have taken the Denenberg "Shopper's Guides" a step further, by compiling detailed directories with listings on individual practitioners. The advantages of these consumer directories are that they remove from the consumer's shoulders the onerous burden of questioning each practitioner before using his services. Instead, a consumer can make a reasoned choice without pressures in his own home.

The first of the consumer directories, "A Consumer's Directory of Prince Georges County (Md.) Doctors," was published in January 1974, by Public Citizen's Health Research Group. During the summer of 1973, Health Research Group staff, posing as citizens new to Prince Georges County, attempted to collect information about the county's practicing physicians. After checking with the local medical society, hospitals, health planning agencies, libraries, and many other organizations, the staff was unable to even produce a list of doctors comparable to the telephone book yellow pages.

A questionnaire was assembled and administered to each of the 463 practicing physicians in the county. Among other items, the questionnaire sought information on the physician's credentials, availability, fees, medicare and medicaid policies, and hospital affiliation. [A copy of a complete physician listing resulting from the questionnaire is attached (see 242)]. The Health Research Group then verified each questionnaire and with a detailed introduction explaining the significance of the information, published the directory.

Since publication of the Prince Georges County directory, at least 30 similar doctors directories have been initiated or published in some 15 States (4). Nearly all have had wide consumer acceptance. One of the directories, for Whatcom County, Wash., was even compiled by consumers with the assistance of the local county medical society.

MEDICAL ETHICS AND LITIGATION

Unfortunately, not all of the doctors directories have enjoyed widespread medical society acceptance. The Prince Georges directory, in fact, met with great resistance—so much so that only 25 percent—or 115—of the physicians agreed to be listed. Similar resistance developed in Illinois, New York, North Carolina, and Virginia.

The basis of medical society opposition has been that publication of certain information, such as fees, billing practices and some credentials, violates the Principles of Medical Ethics, issued by the American Medical Association Specifically, it is argued that listings in the directories violate prohibitions against advertising, despite the face that none of the directories has been published with funds solicited or accepted from individual physicians. Advertising by physicians is also prohibited by law in some 33 States (5).

As a result, litigation has developed in Maryland and New York, and is under serious consideration in Virginia. In Maryland, Public Citizen's Health Research Group filed suit in Federal district court the same day it published the Prince George County doctors directory (6). The plaintiffs contend that the Maryland statute prohibiting physician advertising, as applied to the doctors directory by the Maryland Commission on Medical Discipline, the State and county medical societies, violates consumers' first amendment rights to publish, gather, and receive information for the directory. To date, there has been no decision in the case. A virtually identical suit is pending in Federal district court in New York (7).

Since the Maryland suit was filed, the American Medical Association has liberalized the Principles of Medical Ethics to permit physicians to list information in consumer directories similar to that found in the AMA's own American Medical Directory. Whether this means that a physician could now agree to list his or her fees, for example, still remains an open question. The American Medical Directory does not list physicians' fees.

CONGRESSIONAL ACTION

In short, consumers have begun an important national effort of self-service and self-education. The financial and quality pressures of today's health care have quite logically combined to produce a practical consumer response. The physician directory development is only a beginning health education effort. It must be improved. And, hopefully, with this committee's good judgment, the directory effort, and others like it, will result in better informed consumers of medical care.

[Attachments to Mr. McGarrah's statement follows:]

[EXCERPT FROM PHYSICIAN LISTING—HEALTH RESEARCH GROUP]

MODIN, BARRY, EAR, NOSE, THROAT

Office Information: Office hours: Wed. a.m., Tues., Thurs. p.m.: Silver Spring; Mon., Fri. p.m.: Bowie. No housecalls. Accepts new patients. Does not generally seek walk-in patients. Average appointment waiting time: one week. After hours coverage by answering service.

Fees: Initial office visit: $16.00. Routine office visit: $11.00. Complete blood count: $6.00. Throat culture: $10.00. Requests fee at time of first appointment. Accepts Medicare; and Medicaid (upon referral).

Practice information: Partnership. Office personnel: 1 RN, 1 secretary. Can take samples in office for urinalysis and throat culture. Time allotted per patient: 15 minutes. Secretary or nurse handles complaints, then doctor will meet with patient individually. Languages: English only. Primarly uses Washington Adventist and Holy Cross Hospitals.

Medication and Immunization: Does not prescribe birth control. No routine immunizations.

Education and Appointments: George Washington University (1963). Internship: Ohio State University Hospital, 1 year. Residency: Barnes Hospital Washington University, 4 years (otolaryngology). Board certified. Appointments: none.

NOTES

1. National Ambulatory Medical Care Survey, National Center for Health Statistics; reported in *The Nation's Health*, August, 1975, p. 3.
2. *National Journal Reports*, September 20, 1975, p. 1319.
3. *American Medical News*, November 5, 1973, p. 3. WMAL–TV (Washington, D.C.) News Release, October 22, 1973.
4. Following is a listing of directories as of May, 1975.

GROUP COMPILING DIRECTORIES

Following is a listing of groups which are producing doctor directories:

(1) California Public Interest Research Group (CalPIRG). 621 4th Ave., Room 207. San Diego, Cal. 92101 (in progress).

(2) Colorado Public Interest Research Group (CoPIRG), 1711 Pennsylvania Ave. #203, Denver, Colo. 80203 (in progress).

(3) Peoples Institute of Springfield/Health Research Group c/o Ron Sakolsky. 1805 S. 5th Street. Springfield, Ill. 62703 (completed).

(4) Indiana Public Interest Research Group (InPIRG). 703 E. 7th Street. Bloomington, Ind. 47401 (in progress).

(5) Kailua Health Committee, c/o Anna Wagner. 219 Kailua, Hawaii 96734 (loose-leaf service completed).

(6) Division of Consumer Affairs, Department of Community Affairs and Economic Development, 201 West 14th Street. Wilmington, Del. 19801 (in progress).

(7) Citizens for Hawaii, 205 Merchant Street, Room 18, Honolulu, Hawaii 98813 (in progress).

(8) Massachusetts Public Interest Research Group (MassPIRG). 120 Boylston Street. Boston, Mass. 02213 (complete in 2 weeks, covering 3 areas of the state).

(9) Northeast Community Organization, Minneapolis, Minn. (directory completed for a portion of Minneapolis).

(10) Tompkins County Citizens for Better Health Care. P.O. Box 474, Etna, N.Y. 13062 (directory for Tompkins County, New York completed).

(11) New York Public Interest Research Group (NYPIRG). 5 Beekman Street, New York, N.Y. 10038 (directories completed for Queens County, Syracuse, and in progress for Albany and Binghamton).

(12) Dan Bruch, Lenoir-Rhyme College, Hickory, North Carolina (completed).

(13) Comprehensive Health Planning Council of Northern Virginia. 7245 Arlington Blvd., Suite 300, Falls Church, Va. 22042 (in progress).

(14) Prof. Jerry Richard. Fairhaven College. Bellingham, Washington 98225 (in progress in conjunction with the Whatcom County Medical Society).

(15) Public Interest Research Group in Michigan (PIRGIM). 615 East Michigan Ave., Lansing, Michigan 48933 (in progress).

5. Following is a listing of physician advertising statutes.

Flat prohibition on all advertising

Alaska Stat. § 08.64.380 (Supp. 1971); Ariz. Rev. Stat. Ann. § 32–1401 (Supp. 1971); Ark. Stat. Ann. § 72–613 (Supp. 1971); Colo.; Fla. Stat. Ann. §§ 458.12 et seq.; 9f Ill Ann. Stat. §§ 16a-1, Kans. Stat. Ann. § 65–2836, 2837; Ky. Rev. Stat. Ann. §§ 311595, 600. 438.065, Me. Rev. § 3203–A; 43 Md. Ann. Code § 129; Minn. Stat. Ann. § 147.02; Mont.; Neb. Rev. Stat. §§ 21–2201 et seq.; N.J. Stat. Ann. § 45.9–16 as annon. N.J. Ch. 453 (Laws 1971); N.C. Gen. Stat. § 90–14; 59; Okla. Stat. Ann § 509.736.1 (1971); Tenn. Code Ann. § 63–123, § 63–619; Utah § 58–12–36; Va. Code Ann. § 54–317(13).

Prohibition of Advertising in an Unethical or Unprofessional Manner

D.C. Code Ann. § 2–123 (1966, as amended Supp. 1971); 24 Del. Code Ann. § 1741; Ga. Code Ann. § 84–916; Idaho Code Ann. § 54–1810 (Supp. 1971); Iowa Code Ann. §§ 147.55, .56; Miss. Code § 8893.1; Mo. Rev. Stat. § 334.100; N.Y. Ed. L. § 6509 (McKinney Supp. 1971); N.D. Cent. Code § 43–17–31; S.C. Code §§ 56–1355, 56–1368; Wisc. Stat. Ann. § 448.18 (Spec. Pamph. 1972); Wyo. Comp. Stat. Ann. § 33–340 (1959).

Prohibition of Price Advertising

Cal. Bus. & Prof. Code §§ 651, 651.3; §§ 2361 et seq. (West. 1962, Supp. 1971).

Prohibition of Patient Solicitation

La. Rev. Stat. & 37.1285; N.M. Stat. Ann. § 67–5–9; Ohio Rev. Code §§ 4731.22; S.D. (see misl.).

Prohibition of Misleading or Deceptive Advertising

46 Ala. Code Ann. § 270 (Supp. 1969); Conn. Gen. Stat. § 20–45 (1970); Ga. Code Ann. § 84–916; Hawaii Rev. Stat. § 453–8; Iowa Code Ann. §§ 147.55, .56; Mich. Comp. Laws Ann. § 750.429; Mich. PA 12,368 (1972); Miss. Code § 8893.1; Mo. Rev. Stat. § 334.100; Nev. Rev. Stat. § 630.030 § 631.050; Ohio Rev. Code §4731.22; Ore. Rev. Stat. § 677.190; 63 Pa. Stat. Ann. § 411; R.I. Gen. Laws Ann. § 7–5–1 et seq. (1970, as ann. Supp. 1971); R.I Ch. 100 (Laws 1972); S.D. Comp. Laws Ann. § 36–4–30, Tex. Rev. Civ. Stat. Ann. art. 4505; 26 Vt. § 1398, 1399; Wash. Rev. Code §§ 18.72.030, 19.68.010 (1971).

Source: HMO Sourcebook (1973 Edition), The Health Law Center, Aspen Systems Corporation, Rockville, Md.

6. *Public Citizen et al.* v. *Commission on Medical Discipline et al.*, Civil No. 74–54–B (D.Md., filed Jan. 17, 1974).

7. *New York Public Interest Research Group et al.* v. *Ewald Nyquist et al.*, Civil No. (N.D. N.Y., filed Jul. 7, 1975)

8. Proceedings, AMA House of Delegates, Report of the Judicial Council (Report: C–74), December, 1974.

Mr. McGARRAH. Sallie Adams and Dr. Pauk have some additional comments to make on this bill and also on other directories that have been compiled.

STATEMENT OF SALLIE ADAMS

Miss ADAMS. I am Sallie Adams, a staff member of Public Citizen's Health Research Group. Health Research Group engages in consumer advocacy and research in the areas of health care delivery, occupational health, and food and drug safety.

"Defensive medicine" is a phrase frequently found on the lips of many deliverers of medical care. Today the subcommittee concerns itself with something else—the difference between defensive and offensive health for the consumer.

Many of the same problems exist for the consumer as exist within the health care system. Consumers react to illness, rather than act to assure health. The initial contact between patients and doctor or hospital occurs beyond the point when consumers can make informed choices about which service, which physician, which hospital are most appropriate for their needs.

The reasons for this mistake of consumers reacting when they are already ill are many. Economics looms conspicuously. Geography and convenience figure prominently. Neither can the human tendency to procrastinate what we consider unpleasant or frightening be ignored as a factor. Yet the difficulty which the consumer faces in obtaining correct and complete information about what sorts of services are available in the public health or private sector may well be the decisive factor in discouraging the consumer, when coupled with the reluctance by providers to encourage the free flow of information.

Activated consumers of medical services no longer have to practice "defensive" health. An uneducated consumer of health services cannot deal effectively with a doctor. (S)he cannot choose among services or make informed choices about nutrition, immunization, birth control, prescription or over-the-counter drugs, workplace conditions—in short, all the things which contribute toward "offensive" health. Therein lies the overriding importance of this bill.

There are some unanswered questions implicit in the concepts of "offensive" health and disease prevention. How to educate the consumer? What sorts of materials would be helpful? Who would devise those materials? How would they be available? The bill contains the answers to some of these questions, such as the inclusion of provision for "development of toll-free telephone systems which use recorded tapes or other methods to provide the public with health information, information on available health services, crisis information, and directions for obtaining health-related publications."

The experience of Health Research Group with the directory concept shows the interest of consumers in gaining objective information about all types of medical services in language that they can understand. Since the publication of the Prince Georges County Doctor Directory, Health Research Group has issued a directory for consumers of dental care called Taking the Pain Out of Finding a Good Dentist, and a consumer's guide to finding a psychotherapist called Through the Mental Health Maze which contains a catalog of Washington-area psychologists, psychiatric social workers, and psychiatrists. In addition, Health Research Group has reissued a consumer's guide to medical and dental X-rays and how to avoid unnecessary radiation exposure.

Before discussing those three publications, I would like to add to Mr. McGarrah's testimony that the response to the Prince Georges Doctor Directory continues. We continue to get consumer requests for that book. This is a long time after its original publication. More importantly, new directories are appearing throughout the country; consumer groups and concerned individuals have revised, changed, and improved upon the pioneer HRG model. For example, the Massachusetts Public Interest Research Group, Inc., offered an explanation of how to decipher a prescription, copies of which have been passed out, in its "Consumer's Directory of Doctors with Select Health Care Guides." Over 30 doctor directories have been started or published throughout the country. The enthusiasm with which consumers have received the directories attests to their recognition that they need help in strengthening the doctor/patient relationship and their right to choose the appropriate service for their need.

The directories are tools to educate consumers with respect to the types of questions that they should be asking. The doctor/patient relationship has suffered in no small way because the free flow of information has not occurred as fully as it should. Physicians administer "to" patients, claiming that consumers cannot understand the complexities of modern medicine; yet the law requires "informed consent." Uneducated consumers and informed consent are antithetical. The directories help to provide consumers with the ability to establish the free flow of information and to strengthen the doctor/patient relationship.

Health Research Group's experience with "Through the Mental Health Maze," a guide to finding a psychotherapist, indicates that the difficulty in establishing the right to ask questions and get answers from professionals is not restricted to any single type of health service. HRG has received telephone calls from consumers expressing relief that they now have some idea of what questions to ask to help them judge the type of medical service they require. In addition, they mention how they were not sure what they should or could expect from providers of services before reading the publications, much less how to gain access to that information. They describe their own confusion in trying to find out where to go to get facts. Frequently they detail their attempts to ferret out information relevant to their own care.

If uniformity existed in the various fields of health care there would be no need for the consumer to make judgments about quality. Differences in quality exist from practitioner to practitioner, in hospital to hospital.

Provider attitudes toward consumers also vary enormously. The consumer must be educated into finding out information vital to his or her health. For instance, during dental X-ray, the use of a lead apron and ultraspeed dental film can substantially reduce the amount of exposure to radiation. How many consumers would know to ask in advance whether a dentist takes those routine precautions? Unfortunately, not enough. The other question to ask is how many dentists themselves require such routine precautions in their offices? The answer there is the same—not enough.

During the course of dental treatment medical emergencies sometimes occur from reaction from medication or the like, yet almost two-thirds of the dentists surveyed did not have on hand glucose and epinephrine which should be available in case of an emergency situation. These are the types of questions consumers must learn to ask.

The consumer must become more knowledgeable in his search for services. Furthermore, he must become more knowledgeable in how to judge the quality of those services, as they affect his particular situation. The area of mental health offers another example of the difficulty encountered by the consumer who decides he might want to consider therapy. Until the publication of the HRG directory, the consumer could not assemble a representative list of psychiatrists, psychiatric social workers, or psychologists or gather any information about those professionals' practices—what types of patients they preferred, how much they charged. Nor could consumers determine a professional's availability to patients after hours, their attitudes toward drug therapy or participation of other family members, or making a written statement of therapeutic goals. The representative professional societies provide three names and nothing more. The tales of mismatched patients and therapists are classic joke-lines, yet the person who is not laughing is the patient.

Copies of the various directories and guides which Mr. McGarrah and I have described briefly were made available to the members of the subcommittee. I feel that the questions which may arise as a result of your examining those publications may be more helpful than further general statements from me.

The directory concept represents only one way to educate consumers. There are many more. The important fact is that consumers know how much of a stake they have in asking questions. They must know how much depends on the answers they receive from professionals. From a doctor, anorexia and alopecia sound serious. Loss of appetite or baldness sound less dire. Doctors and consumers must learn to speak the same language. That does not mean everyone should go to medical school. It means that consumers should have a basic body of knowledge about their bodies and health as a positive state of being. Beyond that they should know enough to get the information they require from individuals or instiutions to make sure they are getting the best medical care available to maintain that state of health. To that end, a health education and disease prevention bill makes sense.

Mr. Maguire. Thank you.

STATEMENT OF GEORGE L. PAUK, M.D.

I am George Pauk, and I am a physician. I am appearing as a private citizen, the statement having nothing to do with my primary employment. I appreciate the opportunity to present this statement.

The bill H.R. 8278 is directed toward an important area of preventive health services, public health education, and particularly public health education in the appropriate use of medical services. I believe that there has been a strong tendency for Government programs to fail to produce significant results from education efforts. This appears to be done by the combination of a well intended general mandate lacking specific details and the reluctance of those who implement the change to make serious confrontation with the groups whose interests are in conflict without specific legislative support to do so. H.R. 8278 is a very much needed initiative which would do much for the health of the public, particularly if it is strengthened in several areas which I will discuss.

The potential strength of the initiative of the bill lies in its building on the little used foundation of the influence of competitive choice of health care services by an informed public. This would tend to make health care providers accountable and responsive to the public both as compared to each other and as compared to other services the public utilizes. I believe that the rapidly growing movement for the implementation of consumer oriented health service directories which we started only in 1974, is an example of this type of initiative.

From the remarks of Representative Rogers on Thursday, June 26, 1975, in the House of Representatives, I feel that the bill was intended to encourage the health service and physician directory concept. However, I believe that the bill will unfortunately not fully achieve this because it does not come to a fully practical point of utility to the consumer. In the required development of models and standards in regard to the cost and quality of medical care, section 714(6), there is very little likelihood of the development of adequately detailed information about individual service providers such as is contained in the doctors directories for consumers. As it stands, the models and standards that would develop would simply be actual or theoretical averages or ranges of numbers of costs, and other outcome measures. There is an unfortunate flaw in the nature of medical practice in the great difficulty which patients have in attaining prospective information about the cost and nature of their services with which to compare the models and standards.

The bill would, therefore, not be preventive of costly or poor services except in a manner similar to our present malpractice oriented system. However, even this would be of some benefit if properly developed. The important point should be to supplement the bill by adding provisions to support the development and delivery of practical information to the public which would have a significant effect to enhance competition within the health care market and to make consumers' use of health care both more effective and efficient. The provision of meaningful consumer information would best be done by strengthening section 1714 in paragraph (3) or (6). This could be stated as—

> This would include the publication, with annual updating, of directories of individual physicians and other health service providers specifically including information such as service fees, qualifications, and practice characteristics and any other information judged to be relevant to the cost and quality of care services.

Another key weakness I see is in section 1712(a)(6) which is repeatedly used as the basis for standards in section 1703, "Requirements Applicable to Providers of Institutional Medical Care". The weakness is in the lack of specific mention here of items such as the full nature, consequences, and risks of therapeutic interventions such as drugs, surgery, and other key factors related to quality of care. This addition would substantially strengthen the impact of this bill on informed public choice of medical care.

Another portion of the bill which may be counterproductive is section 1703(d)(1) in reference to denial of payments where preventive health measures are judged to be not cost effective. This issue was most recently discussed at the National Conference on Preventive Medicine and in its task force VII report. I believe the general idea is that it is very likely counterproductive to the public health to require that preventive medicine initiatives be rigorously subjected to cost effectiveness judgments if there are not simultaneously and rigorously applied to disease care services. The technology of assessing cost effectiveness of health initiatives (preventive, curative, or palliative) are poorly developed and subject to vague definition of basic terms which determine assignment of either costs or benefits. The potential for biased abuse either for or against preventive health initiatives is created by this provision in the bill. The logical remedy for this is to compare the cost effectiveness of disease care services in a context in which there is the same or even more effective power of deterrent for these services if they are judged not cost effective. That is, a similar deterrent such as withholding of funds for disease care services should be available to avoid the shunting of health resources away from preventive measures to even less cost effective disease care areas of activity. It may be claimed that PSRO may be intended to be the component which will regulate the disease care areas in regard to cost effectiveness. However, I believe that the PSRO unfortunately has no similar mandate to judge the cost effectiveness of programmatic approaches to health issues. I would recommend that section 1703(d)(1) be changed so as to delete the word "preventive" and possibly add words to further indicate the broader intention of this provision.

Another possible weakness in the bill is in section 1713(b)(ii). The requirement that all centers "shall" be located within established academic or research institutions should probably be moderated to be a recommendation or a requirement for only a percent—50 percent or 75 percent—of the centers. While it is desirable to have centers located so as to benefit from and favor the growth of academic or research centers, this principle should not take complete precedence over the overall goal of having centers which will function optimally to fulfill the intent of the bill. It is sadly true that many of our academic—research institutions are subject to severe conflicts of interests so that they are not necessarily the optimal sites for unbiased public health interest information, education and promotion.

Please consider these remarks as supportive of this bill. An important contribution of Federal and State governmental action in this area could be the encouragement of more widespread activity of this type and the very important institutionalization of periodic—yearly—updating of directory information. Whereas there presently is inadequate funding and lack of specified mandate in these areas, the size of the indicated appropriation in the bill and the specific administrative design, is definitely not excessive and would allow meaningful efforts to get underway.

Thank you.

Mr. MAGUIRE. Thank you.

May I ask, first of all, Mr. McGarrah, Miss Adams, whether you have any additional specific suggestions with regard to the legislation in addition to those made by Dr. Pauk?

Mr. McGARRAH. I would like to say that I think that while the directory efforts that Dr. Pauk detailed ought to be specified in the legislation, I think that these are more subject to perfection and in fact should be improved upon. I don't necessarily think that the legislation ought to detail every single kind of item that ought to be listed. I think that instead what could be done would be to provide grants to organizations such as the public interest groups, to provide incentives for them to develop on their own initiative, perhaps in conjunction with local medical societies, similar kinds of directories or informational efforts.

I think that the bill is going to have, however, to take into consideration that there is a significant body of statutory enactment which runs counter to this consumer education effort, as I was trying to point out. Namely medical practice acts, and similar restrictions exist for attorneys and other professionals. In fact, today the Supreme Court will be hearing oral argument in the Virginia Citizens Consumer Council case which challenges the State prohibitions in Virginia on pharmacists who advertise their fees and this case will have a major impact on this legislation, I think. What it will do essentially, is it argues that there is a first amendment right of consumers to receive information from, in this case pharmacists, and the same theory, as I indicated, is put into place in these doctors directory cases.

Mr. Maguire. Miss Adams.

Miss Adams. I have a lot of comments on the bill. I would be glad to make them available at a later time. Some of my comments are detailed in my complete testimony, particularly the aspects of making information available by national telephone service. I don't think many of us realize the difficulty that various ethnic, socioeconomic, linguistic groups have in knowing where they can get services which are available. I agree with Mr. McGarrah that we need not detail in the bill every type of service which would fall under the bill. Such detailing is unwise and time consuming; however, I do think that the strong provisions for making detailed information available from a national clearing house for consumers is a necessary part of the bill. The provision for the clearinghouse for consumer education should remain, but it is not necessary to include more than general directives about what information would be available from that source.

Mr. Maguire. Could I ask if you would be good enough to supply members of the committee and staff with your more detailed suggestions?

Miss Adams. Yes.

Mr. Maguire. As to how the legislation might be improved—let me ask about the problem of State laws with regard to advertising and other matters. Some of these matters are presently in the courts, as I understand it?

Mr. McGarrah. Right.

Mr. Maguire. What do you suggest, if we want fee information for example, to be available, and I take it that there are some States that preclude that?

Mr. McGarrah. That is right.

Mr. Maguire. Under the advertising prohibition. How do we act to assure that the information is available to the public throughout the country. Is it advisable that this committee should take some action in the bill, do we wait for the courts to process that matter on the conflicting claims of the parties? How do we resolve this?

Mr. McGarrah. I would advise that it would be wise for the committee to include in this legislation a specific statutory preemption similar to what was used in the HMO bill, for example, on advertising provisions. The committee included provisions which would permit the Secretary to essentially waive those statutory requirements and permit HMO's to advertise. I think the same kind of provision could be put in, as I say, preempting those provisions of State statutes as applied to projects which are funded under this act.

I think it is far too important to health education to permit, particularly in an effort such as this which is seeking to develop experiments and to develop new methods of health education, prohibitions of various information such as fees, which are obviously material to a consumer's decision about using physicians services.

In Maryland, for example, we found that in Prince George's County that as many as 50 percent of the doctors who agreed to be listed in the directory require a consumer to pay cash at the time of their visit in the doctor's office. This, obviously, is an incredible burden for many people, particularly in these difficult economic times. In that sense, under the State law in Maryland it would be prohibited for somebody to get that kind of information in a consumer directory. It is obviously, I think, essential to somebody using physicians services.

Mr. **Maguire.** Well, publication by an independent organization of such information would not necessarily be deemed advertising on the part of the physician himself, would it?

Mr. **McGarrah.** That is just the point. In Maryland, what has happened is that the State commission on medical discipline, and also this is taking place in New York and in Virginia—opinions have been issued by the States attorney general, which actually have ruled that if a physician agreed to publish information in one of these directories that that physician will be violating the State medical practice act, and therefore, can be subject to having his license revoked.

Advertising, taking the common law definition is defined as any communication, direct or indirect, about yourself. Even though these directories are not commercial, as I pointed out, they have still been found to be advertising and, therefore, present serious problems for physicians and consumers who want to publish them.

Mr. **Maguire.** If we were to establish that this kind of information could be published in some fashion through the courts or through the kind of legislation that you are talking about, would it be necessary or desirable that doctors be required to supply the information or simply that they would have the option to do so if they wished to, and there would not be anything illegal about it, either supplying the information or subsequently having it published?

Mr. **McGarrah.** I think that it would be probably unwise, I think it would perhaps be unconstitutional if the legislation attempted to force all doctors to be listed. For instance, any doctor who participated in either medicare, medicaid, I think, ought to be required to provide information. I think that that a physician under those circumstances is receiving significant public benefit and it should be made a condition, I think, of participation.

I would not even presume to require it of physicians who decided not to participate in those programs.

Mr. **Maguire.** Thank you.

I would like to turn the questioning over now to Dr. Hyde who is on the professional staff of the committee. He has a series of questions he would like to pursue.

Dr. **Hyde.** Mr. McGarrah, I am not going to take very much time but I had a couple of thoughts.

There is obviously a great deal of variation in fees and charges and presumably there are several reasons for that variation, one of which should be variation in the quality of the service that went with the fee.

What kinds of quality information could you publish with charge or fee information that could be used to help explain the differences in cost?

Mr. **McGarrah.** What we tried to do, for example, in the Prince Georges County directory was to include introductory materials which specifically defined the kind of service that one should expect to receive. For example, in the initial office visit we defined a complete physical examination to include taking history and tests and the like, and when we used this definition in our questionnaire which we supplied to the individual physicians who agreed to be listed they knew that that was the definition we were using.

Similarly, we described various laboratory tests and what you should expect from a laboratory. I mean this is obviously health education and it also makes it pretty specific as to the kind of information that you should expect to get out of one of these directories.

Miss **Adams**. With the Mental Health Directory, which is similar to the Prince Georges County Doctor Directory, but it deals with what you can expect from the psychotherapy and psychotherapist, we did not try to define quality for all people. We defined certain things which we thought were important for a consumer to know and then in an explicated questionnaire described how they could cut, that is to say, that they could do it a number of ways.

For example, if we published a psychiatrist, a percentage evaluated patients who are told they do not need therapy. That could mean any number of things. It could mean though someone takes referrals or it could mean that he felt anybody who walked through the office door needed psychotherapy.

So I think that the nature of the service can be described in such a way as that the consumer can make up his or her own mind as to what constitutes high quality service, because it will vary from person to person.

Dr. **Hyde**. You have indicated such things as "board certified or qualified" and other on paper credentials, types of patients preferred, attitudes toward drug therapy and whether a mental health professional does group therapy, how many people in the group, whether the professional has a collaborative relationship with a physician or other type of therapist, and whether he routinely inform the patient of diagnosis and prognosis.

There was a recent court decision on lawyers' fee schedules holding, as I understand it, that they are illegal. What effect is this going to have on relative value schedules and physician fee schedules?

Mr. **McGarrah**. Well, the Justice Department, the head of the Civil Division, has already in a speech indicated that all professional organizations, this includes lawyers, doctors, pharmacists, and the like, are going to have to reconsider their prohibitions on advertising and specifically price fixing as well. I think it is the American Radiologists Society that has been recently charged in an antitrust action with fixing fees and the Justice Department has just initiated its ligitation there. It is pretty clear, I think, from reading the *Goldfarb* decision of the Supreme Court that any professional organization which attempts in any way to fix fees is guilty of per se violations of the antitrust laws.

Similarly, as a result of that litigation the American Bar Association is now engaged in a dramatic revisal of all its advertising, ethical considerations, and in fact, the litigation which has been initiated in Virginia challenging the advertising restrictions in that State has prompted the ABA to come into court, and actually announce to the court that they are revising all their guidelines in light of the Goldfarb case.

Dr. **Hyde**. I get the feeling from your description of these really very different activities that the barriers to advertising, listing and publication of fee information are coming down?

Mr. McGarrah. Yes, I think it is quite clear that they are. Whether or not, for example, the Supreme Court will permit in its decision on pharmacists widespread commercial advertising by individual practitioners, I think, is an open question. I personally would be opposed to that because I think that it would distort the kind of health information that an individual consumer would be receiving.

For example, it doesn't take much to, think of the difficulties that one would encounter reading the Washington Post if there were some page or a half page ad for practitioners who had large advertising budgets and in the classified section there were smaller advertisements. It would be very difficult to chose between physicians in that kind of setting and, I think, that would distort any kind of health education. In fact, there may be injuries to public health in the sense that some physicians who might have large advertising budgets might be poor practitioners. And, I think, that either a very strong set of regulations, which it would be difficult to enforce, since we have so many problems right now with advertising by commercial enterprises, I would prefer to see noncommercial informational directories similar to those we presented to the committee be permitted and which would give every practitioner in an area an equal opportunity to be listed in a similar format.

Dr. Hyde. Dr. Pauk.

Dr. Pauk. I would make the comment that these changes, these barriers coming down you mentioned, are coming down in response to what I think has been largely private or consumer activity. I would have a fear that a bill that came in now that was not as strong as this bill or perhaps added a few specific points like I mentioned, that it might in a sense create an atmosphere of co-opting some of this private initiative and that people on the outside might feel that they could ease back and stop all of this progress that is going on. So I would ask that you really consider having only a very strong bill.

Dr. Hyde. In your view, do the right thing or do nothing?

Dr. Pauk. That is right.

Dr. Hyde. What kind of demand for your directories has there been? Do you have any feel or sense of what use they have been put to and what effect they have had on people's use of physician, dental, and mental health services?

Dr. Pauk. It is very difficult to really measure because these things are in the hands of the public and I don't think anybody has gone out on a nice study that probably should be done to survey the people and see if they have used them. I can only say they have been sold or given away in large volume and snapped up. It seems like an expression from individuals of their utility.

Miss Adams. I can offer a few rough publication figures for the directories which have been published by the Health Research Group, and I should say that demand for Prince Georges County Doctor Directory continues, we probably receive 5 or 10 calls a week about it. The timelag, 2 years since publication shows a substantial long-term interest on the part of consumers.

We have had to reissue the X-ray directory of which you have a copy. We are publishing in the thousands now. When we decided to publish the mental health directory, the initial publication was 5,000, which is not large in terms of commercial publications. Yet when you consider that we do not advertise—the only notice the public gets of our work is through media coverage of the publication of such a report—response is astounding. Within the first week we had over 1,000 requests for the mental health directory. It was issued on a Wednesday, 3 weeks ago, and the boxes are thinning out around the office quickly, that is a very tactile way I have of telling how they are selling, people do respond.

I have talked to a number of consumers who have just called up and said it is 25 years overdue.

Dr. HYDE. Mr. McGarrah?

Mr. McGARRAH. Well, I could only add perhaps that in Prince Georges County, because all of the resistance from the medical society we published only 1,000 copies of this directory, even though there are something like 700,000 people in the county. We weren't in fact, because it was the first effort, sure either that we would even sell them all or that because of the resistance from the medical society that it would be all that useful, since it only listed 25 percent of all of the doctors. However, all those copies were gone in a matter of about 3 weeks and, as Miss Adams indicates, there have been continued requests for it.

I know from speaking with consumers who are members of some of the neighborhood organizations in Prince Georges County, which I am familiar with, the directory is still in use and in fact in some of the neighborhood clinics it is frequently used as a method of referral to individual practitioners.

In Queens, N.Y., where a directory was published, within 2 weeks they had sold 1,500 copies, just again through news media kind of announcements. It is developing something which is of great demand and interest from people and I think if it were channeled perhaps into official kinds of of organizations or even unofficial ones, such as Welcome Wagon kind of things, if it was routinely available to newcomers in the community, if it was routinely available at hospitals, for example, I think that it would be even more useful and perhaps provide a greater measure of health education for consumers.

Dr. HYDE. Thank you.

Mr. MAGUIRE. Thank you.

I want to thank all three of you for your excellent testimony and your contribution to the work of this committee.

The next witnesses are Dr. Joseph M. Merrill, executive vice president, Baylor College of Medicine, and Dr. Frank J. Weaver, director of Public Education, Baylor College of Medicine.

Will the two gentlemen take their places at the table. Who would like to start?

STATEMENTS OF JOSEPH MERRILL, M.D., EXECUTIVE VICE PRESIDENT, BAYLOR COLLEGE OF MEDICINE; AND FRANK J. WEAVER, M.A., DIRECTOR OF PUBLIC HEALTH EDUCATION, BAYLOR COLLEGE OF MEDICINE

Dr. MERRILL. Mr. Chairman, I am Dr. Merrill, and I will start out. We have a prepared statement that Mr. Weaver will be principally responsible for presenting, but I think the fact that both of us came from Houston last night to appear before you indicates our concern and deep interest in this legislation and we would certainly hope that the Congress will pass something that will strengthen the Nation's program in education of the public about health.

We have also brought with us an audiovisual demonstration that we want to show you that we have developed in Houston toward better education of the public about health.

Mr. MAGUIRE. Do you want to make your statement first before you proceed with the visual presentation?

Dr. MERRILL. Yes.

We think that there are three major problems that could be solved through this legislation; through better education of the public we would have a more effective means of preventing disease; through health education we would have a chance of improving and strengthening the fabric of our society, particularly its family structure, and lastly through better patient education the management of disease could be improved thereby reducing morbidity and mortality.

Our efforts in Houston have been directed mainly at establishing an effective partnership between Baylor College of Medicine, an academic health science center such as was referred to by the previous witness, and the existing system of education and communication in the community, particularly the public school system.

That is very well and good for school children, but we need a greater effort directed toward the adult population in order to combat the various forms of self-pollution that threaten the Nation's health; namely, obesity, alcoholism, drug abuse, and smoking.

The second problem that I indicated might be solved by improving the farbic of our family life deals with the problem of teenage pregnancies.

This is a very important consideration for American society. In 1974, in Houston, there were 5,000 births to children and women under the age of 19. Sixteen-year-olds in that year had 587 births, 91 of them were their second births, and two were having their fourth child. There is no way to maintain traditional family structure under these unfortunate circumstances.

I think it is only though a better education system, ultilizing both mass media and traditional forms of education, that this problem can be addressed.

With that introduction I will turn it over to Mr. Weaver.

STATEMENT OF FRANK J. WEAVER, M.A.

Mr. WEAVER. Mr. Chairman, I am Frank J. Weaver, director of public health education at Baylor College of Medicine.

Through the leadership of this committee, today we have an opportunity for a new era in health care in this country. This means involvement of the people of this country as more active participants in their own health care. As you well know, this will only be accomplished through an organized, integrated, systematic program of public health education, information and promotion.

Though the mandate is clear, no coordinated public health education program has come forth. This is not to say that we haven't seen health education attempts in the past, for we have most certainly. We all have witnessed and in many instances, participated in the mass of health information that has been disseminated throughout our society, particularly during the last 10 years. But what has been accomplished?

There have been some individual successes for which we commend the Congress, and particularly the members of this committee. The National Heart and Lung Institute, the National Cancer Institute, the American Heart Association, and the American Cancer Society have made notable efforts recently in health education. However, with few exceptions, the haphazard approach to health education has generally widened, not narrowed the gap between medical science and community health practices.

The President's Committee on Health Education conceded in 1973 that health information has grown in quantity and quality, but concluded that those responsible for providing health care have not been effectively disseminating information on health. The National Heart and Lung Advisory Council concurred when they stated that—

> The public and professional mass education techniques now used to alter health practices have been notoriously ineffective. They should be replaced by an effective program of education regarding the prevention of disease and the importance of early detection and treatment.

Most importantly, the public must be systematically taught to participate in their own health care and to take a more active role in providing for their own medical care.

We need not remind this committee of the impact of heart disease, cancer, infectious diseases, illegitimate births and other major health problems facing our Nation. Indeed, we have all been overwhelmed by a deluge of impersonal national health statistics on the prevalence and pervasiveness of disease. And this is sad—sad because none of us should admit to being concerned about statistics alone. We are all concerned about people—people who are locked in time and space to social and environmental pressures. We must translate these national health statistics into the realities of human life within our own communities.

We must translate the 350,000 Americans who die annually of a heart attack before reaching a hospital to the corporate executive who died in his office while several people looked on helplessly, unable to administer cardiopulmonary resuscitation for lack of CPR instruction.

We must translate the 360,000 illegitimate births nationally to the Houston girl who has borne four children by the age of 16 for lack of proper sex education and family planning services.

We must translate the 330,000 annual cancer deaths to the woman who suffered a colostomy for fear of annual examination.

And we must develop, implement and evaluate public health education strategies, methodologies, and media to resolve these tragic ironies through communication based on existing knowledge, attitudes and practices of the individuals or groups we are attempting to reach.

During the past 2 years we, at Baylor College of Medicine, have been developing a multidisciplinary public health education program aimed at improving community health practices through health communication research, demonstration projects and the involvement of a host of organizations at the local and national level. It has been a different and challenging process.

As you know, there is limited financial support. There are no clearly defined health education priorities which cut across the categorical approach to health care delivery. There is no mechanism to provide a shared experience for the various local efforts in health education. There is no clearinghouse which could provide a setting for the integration of research and demonstration in this area. And there is no vehicle through which we can catalyze and coordinate the efforts underway within the public and private sectors.

Still, we have been able to develop a program because we believe that Baylor College of Medicine and other academic health science centers have an obligation to the public that extends beyond conducting medical research, educating health professionals, and providing clinical services. We believe that academic health science centers must bridge the gap between academic medicine and the public's health.

We believe that this can only be accomplished through public health education. And we believe that the public has an immense need for the information available in academic health science centers and other health organizations which has been documented through our Center for Public Health Education.

In the spring of this year, Baylor College of Medicine conducted a survey of adults in Harris County, the county in which Houston is located. The study dealt with demographics; health knowledge, attitudes, and practices; media habits or the means through which the public receives information; and the credibility of Baylor College of Medicine as a source of health information. In that study we found that 78 percent of the respondents were interested in learning more about health. We are interpreting this as a local public mandate. It is our belief that this reflects attitudes of people throughout the United States. But how do we reach them?

At Baylor College of Medicine we have established five major sections on health education. The Public Education Section is developing programs aimed at reaching the general community. For example, this section has joined forces with the Houston chapter of the American Heart Association and the Junior League of Houston to provide and evaluate a comprehensive community education program in cardiopulmonary resuscitation. This is a specific response to the nearly 700,000 cardiac deaths—one-fifth of which may be preventable. At the same time, this section is evaluating the effectiveness of the variety of mass, special, and interpersonal media in helping us reach target populations to accomplish other important specific objectives.

The secondary and university education section is seeking to develop self-instructional and other curriculums in health education which can be incorporated within existing educational systems.

The community involvement section is aimed at involving and sustaining the support of other community organizations in helping us maintain a dynamic program of communitywide public health education. To date we are participating with the American Heart Association, Planned Parenthood of Houston, the Houston Independent School District, the San Jacinto Lung Association, the Houston Community College, the Junior League of Houston, the University of Houston, Texas A. & M. University system, the Harris County Medical Society, the Houston Fire Department, the Houston Chamber of Commerce, and the city and county health departments. We are currently planning with still other local organizations to expand our programs.

The Continuing Education Section is developing local and regional programs to keep phyiscians and allied health professionals abreast of the latest advances in basic and clinical research and clinical techniques. More than 72 courses have already been provided this year alone. Furthermore, we are seeking to prepare these medical professionals to play a more active role in public education, specifically patient education.

Along those lines, we are now attempting to set up a fifth section in this comprehensive approach—an undergraduate curriculum for health education. This project is aimed at preparing the new generation of physicians and selected health professionals to conduct health education programs as practitioners and to invite their participation in public health education research and demonstration projects which are already operational.

We have defined our public health education efforts to include patient education, community awareness and response programs, recruiting for informed participation in clinical trials, and programs aimed directly at behavior modification and reinforcement.

With your permission, I would like to take a moment and show you some excerpts we have developed along those lines. It will take about 7 minutes.

This first spot is an excerpt from an outpatient information system that is aimed at Mexican Americans. We have a network of seven satellite clinics in Harris County to provide medical services to these people. One of the problems that we have is the question of diet. We took the liberty of translating this for you.

The second excerpt is from our hypertension outpatient clinic at Ben Taub General Hospital where we are seeing about 500 hypertensives now. The object is to reinforce the physicians' and nurses' information through a simple slide presentation on what they can do to adhere to medication and the diet that is prescribed for them.

During the past year, we conducted a communitywide screening of the Jewish community for Tay-Sachs disease. Part of that was a sound/slide package that was shown throughout the Jewish community.

We believe that recruiting for major clinical trials is a very good opportunity for educating the public about health.

This next segment is a 30-second television spot to recruit men between 35 and 59 who have high cholesterol.

The final excerpt deals with diet behavior in specifically diet modification. It is a major program underway now through support from the National Heart and Lung Institute.

Each of these programs in their entirety have been evaluated, and we would be happy to supply the results of that evaluation to the committee if you are so interested.

Mr. Preyer [presiding]. Could I ask you a question? You mentioned some were used in the outclinic; were some used over educational television, and what are the variations?

Mr. Weaver. Yes, sir. The first segment was used in an outpatient clinic, as I mentioned. The second one dealing with hypertension is used and still is in the outpatient clinic of Ben Taub General Hospital. The Tay-Sachs presentation was used in interpersonal meetings of various synagogues and Jewish comunity center groups throughout the

Houston area. The television spot you saw with the woman talking about her hubsand was used on the commercial television stations, and there is a similar radio spot that was used on 22, and is currently being used on 22, radio stations in the Houston area.

The diet modification program is used in an interpersonal setting at Baylor College of Medicine itself.

We have other materials that we didn't bring along today that are used in the school systems, particularly the Houston independent school district; and we have other printed matter that we developed to support these programs and others that have evolved.

Mr. PEYER. Thank you.

Mr. WEAVER. Whatever the element of public health education, we feel that we are locally and should be nationally attempting to accomplish one or more of the following goals: Attract public attention, create public awareness, insure public understanding, gain public acceptance, secure public response, and effect public change or action.

Individually, these are difficult goals to achieve and measure. Collectively, they require a systematic program of execution and evaluation. In other words, a methodology—a methodology that should be somewhat standardized so that health education programs can be replicated and evaluated by others and so the experience gained in one area can be shared by another.

We believe that such a methodology should incorporate:

1. A clear definition of the publics we are attempting to reach.
2. A statement of clear, measurable program objectives.
3. A review of the literature and data available on the subject to establish a meaningful data base.
4. A clear definition of the theme(s), appeal(s), and message(s) to be employed.
5. Careful selection of the appropriate media to be employed and documentation for its use.
6. Well-established evaluation procedures designed before the program is implemented.
7. A systematic and well-documented execution of the education, information, or promotion program.
8. Complete implementation of appropriate evaluation measurements.
9. Candid reporting of the results of each venture in public health education, and
10. Revision of the program based on previous experience.

In short, we believe that unless comprehensive public health education programs are incorporated locally within academic health science centers and other health organizations, through the leadership and coordination of a fully integrated national health education and promotion program, then the dichotomy between medical science and community health practices shall continue to exist.

We feel that legislation introduced in this committee is the type of perceptive action we need to meet the public mandate for health information. There are several points which we would like to emphasize.

First, we feel that the dual approach is desirable to the success of a national public health education program insomuch as we have had substantial experience in utilizing the private and public sectors for this purpose. If a mechanism for providing participation between the public and private sectors is not developed, we are unlikely to implement a unified effort designed to meet the public good. Simply stated, a national forum must be created for the exchange of ideas, information, and expertise, while coordinating program planning and priorities between the public and private sectors.

Second, we favor and support the development of a comprehensive health education program to meet the varying health information needs of our society that is more than a categorical approach to health education. However, we urge this committee to provide for the continuance and integration of health education programs that have demonstrated sound design and indicate early successes so that they may not become lost or neutralized in the startup of either a National Center or Institute for Health Education and Promotion.

Third, we would urge the committee to consider including continuing professional education as an important element of a comprehensive health education effort. This would provide the means to better prepare physicians and allied health professionals to play the central role in encouraging consumers to participate in their own health care. Baylor College of Medicine's survey has shown that people expect their physician to be the primary interpersonal source of health information.

Fourth, we strongly favor the development of local research and demonstration programs in health education as outlined in this legislation. The results of these local programs should be available through the National Center for distribution throughout the country.

Fifth, we believe that the academic health science centers should be specifically challenged to participate directly with other local organizations in demonstration projects, health communication research, and education and promotion evaluation.

Finally, we would urge this committee to sustain the quality of participation in a national program of health education, promotion, and information by providing for a competitive grant and contract proposal review process.

Mr. Chairman, it has been a pleasure to be with you and the committee this morning. We sincerely acknowledge your unfailing interest and inspiration which you as a committee are providing to the health professions. We wish you Godspeed in the work you have before you. If at any time we can be of any assistance in providing you and the committee with additional information, please don't hestate to call upon us. We shall be happy to attempt to answer any questions which you or the committee may have concerning this testimony. Thank you.

Mr. PREYER. Thank you very much, Dr. Merrill and Mr. Weaver, for some very interesting and strong testimony. I apologize that the full committee is not here to hear this testimony. It is so good we ought to all be hearing it and all take it to heart. Our chairman is in an energy conference meeting this morning, which has taken some of our other members away. They are missing some very good testimony.

Certainly Baylor has done a great deal to bridge the gap, as you put it, between academic medicine and public health. If we had a few more institutions operating the way yours is, we would not need to be considering a bill here, I do not think. You have certainly done a great job.

Mr. Carter.

Mr. CARTER. Thank you.

I certainly want to agree with what you said about the program at Baylor. I think it has been extremely helpful and serves perhaps as a guidepost for other programs in our country.

I am glad to see these distinguished gentlemen so interested in what I consider to be a worthwhile project.

What has been your experience in obtaining funds necessary for the program that you have?

Dr. **Merrill**. The office that Mr. Weaver operates out of is funded as a direct line item on the budget of the college of medicine, and of course, we compete in some instances successfully for national funds through the National Institutes of Health and other Federal agencies to support activities of this sort, although they have been extremely limited in scope.

It is a combination, as most academic medical centers are, between philanthropy, State support, local support, and Federal support.

Mr. **Carter**. You have used local, State, and Federal, also.

Dr. **Merrill**. Yes, sir.

Mr. **Carter**. And as well funds from philanthropic groups.

Dr. **Merrill**. Yes, sir.

Mr. **Carter**. Do you feel there is a need for a National Federal entity to coordinate health education activities?

Dr. **Merrill**. Yes, sir.

Mr. **Carter**. What have been some of the problems your group has encountered in trying to establish effective health education programs?

Dr. **Merrill**. Our major difficulty in dealing with what you would call the Federal sector has been a central agency that is addressing itself to the problem of health education. The patchwork quilt of the agencies that exist at the present time are not funded adequately to engage in a national program addressing itself to education of the public about health education such as you have seen this morning.

Mr. **Carter**. How can we help to address these problems through legislation?

Dr. **Merrill**. Well, I think that the bill that you have introduced, Dr. Carter, covers most of those elements.

Mr. **Carter**. Thank you, sir.

I notice from time to time some portions of HEW and NIH and our communicable disease center in Atlanta put out pamphlets concerning different diseases, such as the undersirable effect of high cholesterol and so on. Do you think these pamphlets are a very effective means of educating our patient or not?

Mr. **Weaver**. I think some of the pamphlets are very effective. I think part of the problem we have had in the past with pamphlets that have been produced solely nationally without the input of regions of the country has been they do not take into consideration the socio-cultural differences of this country and there is this need for localization in order to make the information contained within thees documents more meaningful to the target population.

So I would say that some of the efforts have been effective but we need to concentrate more on a dialog between these national efforts and regionalization so to speak of these programs.

Mr. **Carter**. I like your approach. I must say when people receive these pamphlets without their being extremely attractive, they throw them aside. We have got to have a more effective means of reaching the people, attracting them, as I see it.

Mr. **Weaver.** Dr. Carter, I might add the survey we conducted shows that pamphlets are by and large ineffective unless they are handed to the individual by a physician and then they are an effective source of information.

Mr. **Carter.** What mechanism do you feel is the best for funding these programs?

Dr. **Merrill.** I think that, as far as we are concerned, it should be funded through a Federal agency and the funds distributed through national competition based on merit review.

Mr. **Carter.** Yes, sir. I know competition means a lot. The most effective programs probably would get the most money or might get the most money. That is not always true. But still, perhaps the most worthwhile program should be emulated, as I see it, in other areas. Should grants and contracts be given directly to the recipient or should they be distributed on a regional or even a local basis?

Dr. **Merrill.** My own feeling about that is that it is one chief merit most likely, after all this is a relatively new area that medicine is given to explore through national competition.

Mr. **Carter.** Through national competition.

Dr. **Merrill.** Yes, sir.

Mr. **Carter.** What has been the response of the public based on your experience with your project.

Mr. **Weaver.** It varies from project to project. I think perhaps our greatest success to date has been in the cardio pulmonary resuscitation instruction program which is only 2½ months old now. We operate this program three times a week and we are booked through April of next year and the responses are still coming in.

We will be evaluating that program in terms of how long the public retains that information.

The second most effective program I think has been the program in the neighborhood clinics, the outpatient program I think has been the program in there and there we have adopted that, because of this system in the clinics we have motivated the outpatient to seek additional information from nutritionists or other allied health proposals while they are in the clinic that they might otherwise have done—at least our pre-test they would not have otherwise done so.

Mr. **Carter.** Have you had any dealing with the center for disease control and its Bureau of Health Education in regard to your health projects?

Mr. **Weaver.** Mr. Ogden has been down to visit us about a year ago now, and was very enthusiastic about our work there but informed us at that time they had no means available to support any of our activities or the expansion of any of our activities.

Mr. **Carter.** And yet they are opposing this, as I understand from their testimony on the Senate side because the Secretary has authority, but evidently not the money, under section 301 of the Public Health Service Act. They feel this legislation would complicate the situation. What is your response?

Mr. **Weaver.** My response to that is that this legislation before this committee would streamline the situation in that the Bureau of Health

Education as it is now operational will not accomplish the objectives set forth in the bills before this committee.

Mr. CARTER. What would you include in your definition of health education?

Mr. WEAVER. I would include patient education both inpatient and outpatient, support for what we would call community awareness and response campaigns. Immunization campaigns would be an example of that. Recruitment for clinical trials to support the clinical trials under way in this country and comprehensive programs aimed at behavior modification and I would add one element to that and that is training offices and allied health proposals to take a more direct role in public education.

Mr. CARTER. Do you feel, too, that the physician on occasion for instance, if he had a diabetic patient particularly, should take time to go over the patient's diet carefully and the amount of insulin he should take and tell him the damages of course if he should have an overdose? Do you think he should also inform him of the possibility of coma if he fails to take enough insulin?

Mr. WEAVER. I definitely do. I think that we know that the physician is and should be the most credible source of health information. I think it is our responsibility to reinforce his potential role in the health education process and to find new means for getting the public involved in their own health care.

I do not see public health education as a replacement of the physician's role in working directly with patients.

Mr. CARTER. It is your idea and I think I agree with you, that you must have involvement of different groups in this.

Mr. WEAVER. Yes; it is and must be a multidisciplinary approach.

Mr. CARTER. Health educators, paramedical personnel, nurses, and physicians.

Mr. WEAVER. And communicators, yes, sir.

Mr. CARTER. And in Harris County, I believe you are a resident of that great county, down in Texas with which I am quite familiar. I have been there many, many times. I have seen your complex of schools. It is a fine complex and offers a great deal to our country in the treatment not only of heart disease, cancer and so on, but for many other diseases.

I want to compliment you on that.

In your county, in your public health office there, you have public health officials who are interested in health education.

Mr. WEAVER. Yes; we do.

Mr. CARTER. And nurses who assist you in your programs.

Mr. WEAVER. The hypertension program that we talked about earlier is directed by the nurses in our complex.

Mr. CARTER. What about your level of immunization and preventive medicine in Harris County? What percentage of your school children and preschool children are immunized?

Dr. MERRILL. I could not give you an accurate figure, but it is not what it ought to be. The reason it is not what it ought to be is because of lack of education.

Mr. CARTER. We are told there is a dropping off in the percentage nationwide.

Dr. MERRILL. That is correct.

Mr. Carter. In your schools in Harris County are courses in health and hygiene taught?

Mr. Weaver. There are some courses now and we are developing—we have a program with the Houston School District at Baylor College of Medicine we have the Nation's first high school for health professionals in Baylor. Through that program we have developed a model curricula that are being implemented and will be implemented through the Houston Independent School District. We are now talking about 10 other school districts in the greater area, about their adapting this health curriculum.

Mr. Carter. Again, I want to compliment you on your statement and your presence here. Your programs are certainly appealing, and I would think effective. To be effective they must appeal to all of the people or the majority of them. I know our pamphlets are helpful, but sometimes they are not cultural. They are not attractive and they do not induce reading.

I like your approach. Thank you.

Mr. Weaver. Thank you, sir.

Mr. Preyer. You are developing in one high school a health education curriculum for all high schools?

Mr. Weaver. Yes. The high schools provide a kind of laboratory setting for the development of this curriculum. It is in the pilot test stage, then it is sent out to other schools for implementation.

Mr. Preyer. How about in elementary schools, has anything been done there in the Houston area?

Mr. Weaver. We have two programs, one that is under way, it is a program aimed at helping children to avoid the habit of smoking, and that was begun in the elementary schools. It is under the direction of Dr. Richard Evans of the University of Houston working through one of our programs. Dr. Merrill has been working on another program with the Houston Independent School District. I am sure he would like to talk about that in terms of sex education and family planning.

Dr. Merrill. As you know, that is an extremely sensitive subject to bring up in a school district and our approach to that has been by also having what we call parenting conferences that involve representatives of the administration of the school district, representatives of the medical school meeting jointly. I was at one of those about 2 weeks ago when we must have had at least 250 mothers of children who were concerned about sex education. This is something that we are biting the bullet on. We do not know what the repercussions will be but if we are going to address the problem of teenage pregnancy, I do not see any other way to get at it.

Mr. Preyer. Thank you.

Mr. Carter. Mr. Chairman, if you will yield on that, I notice you brought up Tay-Sachs disease, it is very interesting it was included in our list of genetic diseases for screening.

Mr. Weaver. Yes.

Mr. Carter. And counseling. All we can do is counsel them as to what might happen if they have the training. Of course education in all genetic disease is the basic way in which we can avoid troubles in the future. Not only Tay-Sachs but sickle cell anemia and all the rest should be included. There are so many diseases and we can only control them effectively through education and counseling, as I see it.

Thank you, Mr. Chairman.

Mr. **Preyer.** Thank you very much. You did mention that you had tested the effectiveness of your film on it and that you had some result.

Mr. **Weaver.** Yes, sir.

Mr. **Preyer.** I think the committee would be interested in that. How do you test effectiveness of them?

Mr. **Weaver.** It depends on the particular program. For example, the Tay-Sachs program which Dr. Carter was just talking about a moment ago, we have done two things. First off, all we do a pretest on the media itself to see if it is understandable, if the people understand the message, indeed if it accomplishes the objective set down for it. Then when we go out and give a presentation, we evaluate it based on how many people actually sign up to be screened and then of those people who actually signed up to be screened, how many of those people actually came in to be screened. So that is how that particular package is evaluated.

The coronary prevention television spot you saw is evaluated based on the number of phone calls we receive per week. Then of those phone calls, how many individuals actually come in to be screened and then actually participate in the program. We found by the way at least in that one project that television is the most cost effective medium available for activating these people. In other words, getting them into the project and we consider it a form of health education of we impart a certain amount of information and ask them to take specific action and they do.

Mr. **Preyer.** I think any material you might have on that——

Mr. **Weaver.** We would be glad to forward all of that to the committee for your review.

Mr. **Preyer.** Thank you. We certainly appreciate your being with us today and this has been very helpful.

Mr. **Carter.** Do they cooperate with you well on this public television educational TV?

Mr. **Weaver.** No; I do not want to say they do not cooperate. They are very receptive to our ideas. We have a problem in using local public television at least in Houston, in that they have very limited funds to develop programs to support our activities and we do not have the budget available to fund the production of television programs through the public broadcast system. We have been on the other hand very fortunate in Houston in that all five of the commercial stations have donated their production capability either for the production of 30-second spots, as you see or for full length TV programs. So we have not been using the public staitons.

We would like to very much. They would like to work with us. It is not for lack of a spirit of cooperation, but a lack of available funding.

Mr. **Carter.** It speaks well for the private sector.

Mr. **Weaver.** It does indeed and I think it points to the opportunities ahead if we can get this program moving forward.

Mr. **Carter.** Thank you.

Mr. **Preyer.** Thank you very much.

Mr. **Preyer.** Thank you very much.

Our next witness is Beverly Ware, D.P.H., president, Society for Public Health Education, University of Michigan, School of Public Health.

STATEMENT OF BEVERLY G. WARE, D.P.H., PRESIDENT, SOCIETY FOR PUBLIC HEALTH EDUCATION, INC.

I am Beverly Ware, assistant professor of health education, University of Michigan, School of Public Health, Ann Arbor, Mich., and currently I am president of the Society for Public Health Education. This organization has a membership of over 1,125 persons, most of whom are engaged full time in the practice of health education in a variety of settings, and in a wide variety of educational activites. Some, like myself, are training future health education practitioners, some are engaged in research activities, some direct or coordinate consumer health education programs in hospitals and other health care delivery settings, some teach in or coordinate health education programs in schools, and some function within communities to plan and implement educational programs for the public. Our members are often called by titles other than "health educator," yet all have a common goal: "to promote, encourage, and contribute to the advancement of the health of all people through education."

Over the years of its existence, The society has been striving not just for the development of health education, but of the professional practice of health education as well. We are a relatively young profession, but getting mature.

SOPHE will celebrate 25 years of existence this week at its annual meeting in Chicago. We have been following closely the "rebirth" of interest in health education that has taken place over the past few years, culminating in legislation specific to health education being introduced in quantity as never before. While we rejoice in the interest and attention to health education, we also recognize that health education in no way is the answer to all of the problems besetting the delivery of health care in the United States today. We realize that planning and implementing educational programs which will educate consumers, and so reduce costs of care or unnecessary visits to hospitals or clinics, will require massive infusions of money and personnel.

In 1973, at its annual meeting in San Francisco, Calif., the membership adopted a policy statement in support of a National Center for Health Education outside of Government, a Federal focus for health education within the Government, and that health education become a funded benefit by third party payers [see appendix A, p. 269].

Each of the three bills to which I will direct comments, addresses at least one of these issues, and I will comment on them both from the interest SOPHE has in the profession of health education, but more importantly, its concern with the practice of health education.

H.R. 3205 "NATIONAL HEALTH EDUCATION POLICY AND DEVELOPMENT ACT"

In section 1705, "grants," five areas for funding are mentioned, all of which involve public information giving or the dissemination of information. In none of the other provisions is the term "health education" defined, so we conclude that if giving information is seen as "health education," that is a very narrow definition of the field.

While a health education administration would be established within the Department of Health, Education, and Welfare, there is no indication where the eventual placement would be. It would seem a bit wasteful not to build on the start already made by the Bureau of Health Education, now located in Atlanta.

There is no provision for the appointment of a professional health educator on the advisory council. The qualification of "two health professionals (other than physicians) involved in providing preventive health services to patients" is certainly not specific to a professional health educator, and if that is how a health educator is defined, that is a narrow definition of health educator.

Section 1704 authorizes study and investigation on such widely divergent areas as (1) the current status of health education in the United States and (2) factors bearing upon a consumer's motivation for preserving his own health and utilizing health services. Since "health education" is not defined, it is difficult to know what would be investigated concerning the status of health education.

Would it be a study of how well health education (and health educators perhaps) are accepted by (1) other professionals in the health field (2) users of service? Or is this meant to be a "state of the art" study? Unfortunately, the bill utilizes such loose wording in this section that it is very hard to decide what exactly would be done. A study of the factors bearing upon a consumer's motivation with respect to health might not be nearly as essential as studies of applications of factors we already know about motivation in programs designed to assist consumers in preserving health and utilizing health services.

While H.R. 3205 does seek to strengthen the Federal commitment to the field of health education, the narrow definition of health education and poorly defined and conceived approaches limit the possibilities and implementation of this legislation. Moreover, there is no mention of a need to examine manpower requirements for the development of competent health education practitioners and practice.

H.R. 8278 NATIONAL HEALTH INFORMATION, EDUCATION, AND PROMOTION ACT OF 1975

Before I get to the specifics, a general comment.

Throughout title XVII Health Information, Education, and Promotion, the term "Preventive health services" is coupled with information, education, and promotion. In this context, the term is confusing. "Preventive health services," as we use the term is a much broader concept than health education. Health education can be considered as one of many preventive services but it is also an integral part of preventive services such as immunizations, screening of children for physical, learning, and behavioral disabilities, et cetera. As I read title XVII it provides for health education, not preventive health services. We suggest the bill would be clearer if this term was not included.

The specific sections of the bill on which I would like to comment include:

Section 1713(b)(1) provides for at least 10 health education centers to be operational in each fiscal year. The idea of dispersing research and program development activity from the national to the local is sound. We question, however, where the responsibility for this aspect of the work should be. It might be assigned to the private sector so as to provide the checks and balances necessary in our political system.

We question also whether centers—formal organizations—offer the most appropriate model. Perhaps a more flexible model would be a national center which contracts with appropriate local groups. This does not lock one into organizations; it leaves one free to work in a number of geographic areas which can be selected on the basis of need and talent available.

SECTION 1714 INFORMATION PROGRAMS

This section is concerned with the provision of information about a variety of topics. We feel it is important to remember that information alone with opportunities for reinforcement could result in frustration rather than learning. If the drafters of this legislation consider the issues addressed in this section to be sufficiently important to be singled out for special mention, and we agree that they are, then these issues should also be mentioned in sections 1712 and 1713 as subjects appropriate for research and community programs.

(1)(A) This section requires publication of a health education journal for health professionals. There are several existing efforts in this regard. The Society for Public Health Education publishes a quarterly journal, Health Education Monographs. Monographs keeps the practitioner up to date on research and demonstration programs and theoretical developments. The International Journal of Health Education and Health Education Reports (HER) are also published quarterly. HER is a practitioners bulletin providing news of innovative programs, new literature and "how to" information. In addition SOPHE and other professional organizations have membership newsletters which update the reader on happenings in the field. If you wish to reach the health professional who is not a health educator, you are more likely to do so by including articles on health education in their professional journals than in publishing a new journal. Professionals already have a difficult time keeping up with all that they now should read.

(1)(B) This section requires the publication of a journal for the general public. This does not seem necessary since there are many commercial publications for the Mayman related to health such as Today's Health, Parent's magazine, and Family Circle. Nearly every woman's magazine carries a health column. Some of the best of these are found in the most inexpensive publications on sale in every supermarket and grocery store in the country.

(2) We agree completely with the intent of this subsection which provides for a continuing review of health related materials in advertising "to evaluate it's content and impact." We question whether the methods suggested for dealing with information presumed to be false and misleading will have the desired effect. For example, subsection (C) states "the communications media which presented such advertising shall be given information for transmittal to the public served by such media which is responsible for the false or misleading part of such advertising." The assumption that the media will use this material may not be valid. Further, there is no guarantee that those who heard the incorrect message are going to hear the correct message. Perhaps we need rather to look at ways to deal with false and misleading advertising, then design programs more realistically based.

(3) The intent of this section which is to provide materials which

can be easily read and understood by people of different racial and socioeconomic groups is to be applauded. We agree that all materials which are available are not necessarily understood by people of all cultures of socioeconomic classes. The needs of these groups, however, are so diverse that materials useful to them are better tailored to their needs at the local level as programs are developed. Adequate funding of the community program section of the legislation will provide for these kinds of educational tools.

(6) The intent of this section, as we read it, is to create a more sophisticated public in relation to the selection and use of medical care resources. While the publication referred to in this section may be one useful step in this direction it is only one step in the process of educating the public about utilization and choice of resources. Provisions must be made as well for other means wherein the individual's understanding of these and other health care issues can be furthered, such as community discussion groups. We recommend consideration of inclusion of this provision in section 1713 of this legislation which deals with community programs. This could be one of the demonstration programs to be supported under subsection (a)(1).

(7) Again, we applaud the concern of the drafters of this legislation with the public's understanding of health insurance policies. A phrase included in this subsection "the ratio of the amount paid an benefits to the amounts received as premiums" is not appropriate for this legislation in our opinion. It raises the cost-profit issue which is related to but different from benefits provided. This phraseology suggests confrontation with insurance companies about the cost versus the profits of health insurance.

(8) The idea that there are differing points of view for certain therapeutic techniques, some new and some not so new, is one with which the public should be acquainted. Again, we find ourselves in agreement with the intent of the drafters of this bill. However, the task of "assessing the effectiveness, safety, cost, and required training and so forth" for each of these regimens as the bill requires boggles the mind. Demonstrating the pros and cons of one of two therapys, would provide a basis for discussion of others. If the public is trained to ask the right questions about all therapeutic regimens and to realize that many are not sure-fire cures, and may have adverse side effects, then we feel the intent of this section will be effectively carried out.

H.R. 5839 NATIONAL HEALTH EDUCATION AND PROMOTION ACT OF 1975

This bill contains provisions for the establishment of a National Center of Health Education and Promotion within the Department of Health, Education, and Welfare, and for a nonprofit Institution for Health Education and Promotion outside of government. As mentioned earlier, our organization has for 2 years supported the development of both of these, and we were delighted to see this bill introduced in April, and were also involved in the draft stages of this legislation.

As is true with H.R. 8278, we are concerned with the use of the term "preventive medicine." We suggest that the focus of term as used in the bill is on the contribution of health education within preventive medicine, and as such should be clarified in the wording.

We recommend that persons with training in community health education be utilized both as staff and to give leadership to many aspects of the bill. For example, many provisions will need additional manpower implementation. While the bill specifies the development of health education and preventive medicine model curricula and the establishing of continuing education and workshop programs (C and D section 103(b)(1), there are no provisions within this section or other parts of the bill for the training of the necessary manpower to accomplish these tasks. We recommend utilizing accredited programs of health education for increased training in and for health education.

The functions of the institution as outlined in title II are not distinct from provisions included within title I. Activities should be complementary, not overlapping. The institution should function to develop policy and to provide direction and support for the proposed national center.

I have taken the comments made concerning this bill from the discussion of the SOPHE board of trustees at its meeting in May. The Board supported both this bill and Senate bill 1466 as steps in a positive direction toward developing a firmer practice base for health education, and a creative approach toward improving the health of all people through education.

The executive committee of SOPHE discussed H.R. 8278 during its August meeting. There was agreement that this bill was the most comprehensive legislation thus far introduced with respect to health education. The comments made concerning this bill today reflect the discussion of this bill.

Thank you for the opportunity to present our views today.

[The appendix referred to follows:]

APPENDIX A—A POSITION IN SUPPORT OF A NATIONAL HEALTH EDUCATION PROGRAM

To stimulate an effective national, state, and local health education effort, the Society for Public Health Education strongly recommends the following actions:

Include patient education as a reimbursable service under Medicare, Medicaid, and other health insurance programs;

Establish a health education focal point in the Department of Health, Education, and Welfare;

Create a non-profit National Center for Health Education.

These actions would develop capabilities of agencies, organizations and communities across the country to help people:

Achieve physical, mental, emotional, and social well-being;

Prevent thousands of premature deaths;

Prevent millions of days of unnecessary disability, institutionalization and absenteeism;

Contribute to containment of skyrocketing medical care costs.

The cost of health care in this country is rapidly approaching $80 billion a year, most of it for crisis-oriented, episodic medical treatment. Only a small fraction of this amount is invested in helping people attain good health through preventive action.

The solution of today's health problems requires increased understanding and action by all persons. The individual decides whether or not to assume responsibility for adopting sound personal health practices. The individual must take the initiative if he is to benefit from detection tests, prompt medical review of symptoms, and appropriate use of other services. He should voluntarily participate in community action for better environmental conditions, improved health services, and removal of social barriers (e.g., unemployment, inadequate education, poor housing, discrimination) that interfere with the achievement of optimum health. Effective education in health care facilities, schools, industry, and many other settings is essential to promote informed decision-making and responsible action to reduce disability and premature death and to promote vigorous health.

Often, attempts to educate the public about health fail to make effective use of what is known about how people learn. Educational experiences are planned unscientifically—or not planned at all. Too often, reliance is placed solely on one-way information-giving approaches rather than a combination of education approaches tailored for each situation. Mass communications media can play a useful role in stimulating awareness and interest, but face-to-face or problem-solving educational methods have proved more effective in helping people deal with the complex behavioral problems that contribute to many of today's health conditions.

The critical need for informed, responsible action by individuals, agencies, organizations, and communities, and for appropriate application of sound educational principles and methods in health programs makes it imperative that high priority be given to upgrading and extending educational endeavors directed at reducing health problems.

HEALTH EDUCATION AS A REIMBURSABLE SERVICE

The Society for Public Health Education supports the action taken by both tax-supported and private health care programs to make health education a reimbursable service in health care facilities. This action assures that organized systems include mechanisms to assess each patient's educational needs and provide ways to meet them, utilizing a team approach.

The nation continues to increase spending for health care services. Studies describing health education activities have reported cost containment and improved medical care outcomes resulting from organized health education efforts. The Society supports the utilization of health care dollars as efficiently and effectively as possible. This includes appropriate utilization and timely access to health care.

The action taken by tax-supported and private health care programs includes acceptance of the following criteria for reimbursement of health education services:

1. Health care facilities will, at the request of the administration, the medical staff, and with the concurrence of the Board of Trustees, create a patient education committee comprised of representatives from the medical staff and departments as appropriate.
2. The function of the patient education committee will be to develop health education delivery systems.
3. The patient education committee will function under the direction of a person that has been trained in educational methodology.
4. The content of each response will be communicated to the physicians on the staff so that they know prior to writing the treatments just what the hospital proposes to do.
5. The hospital will establish a charge for each structured response. This charge will be in addition to the bed rate.
6. Physicians would initiate action by writing an educational treatment. It would indicate the subject area in which the patient and/or his family is to be educated.
7. The patient's record will show that educational experiences ordered were provided to the patient and/or members of his family.
8. The patient's bill will include an itemized list of specific patient education services delivered. In prepaid health systems patient education benefits will be included in the capitation rate.

Organizations concerned with assessment of the quality of medical care for example, the Joint Commission on Accreditation of Hospitals and Professional Standards Review Organizations—will be asked to review patient education components of health services.

Congress will be asked to incorporate provisions for health education in current and future legislation pertaining to the delivery and financing of health services, such as national health insurance programs and health maintenance organizations.

FEDERAL FOCAL POINT

The Society proposes the establishment of a Federal focal point for health education within the Department of Health, Education, and Welfare. Such a focal point would facilitate coordination of the Department's health education activities with those of other Federal agencies. It would also provide a central resource for those who plan and conduct local and state health education programs that are supported by Federal funds. The local community is the appropriate focus for most health education effects, but those who develop and implement community programs need and want national resources they can use for information, ideas, and consultation. A Federal focal point should also provide a means for program advocacy, coordination, and collaboration with the private sector through such mechanisms as the proposed National Center for Health Education.

This health education focal point should be located sufficiently high in the administrative hierarchy to be effective. It should be staffed with specialists of sufficient competence to provide sound professional health education leadership for all technical program staff. An advisory group consisting of respected leaders in health education and related fields, as well as consumer representatives, should guide the unit's activities. Further, this focal point should:

1. Assure adequate planning of the educational aspects of Department programs and integration of health education with other program comonents;
2. Encourage allocation of sufficient resources for health education research and evaluation projects, manpower activities, and technical assistance (especially to reinforce community programs);
3. Coordinate educational efforts of various programs for maximum effectiveness and efficiency;
4. Provide all programs with access to methods and resources found to be effective in other Departmental programs.

Congress will be asked to incorporate a Federal focal point for health education into the Public Health Service Act.

NATIONAL CENTER FOR HEALTH EDUCATION

In our pluralistic society, it is essential that the many agencies and organizations interested and active in health education programs have a central source for coordination, planning, development, and evaluation. The Society proposes that a non-profit National Center for Health Education be created for this purpose.

The Center should be staffed by professionally trained health educators and related personnel. An advisory board should be established consisting of health educators and related specialists, as well as consumer representatives. Arrangements should be made for close coordination and communication between this advisory group and the advisory group proposed for the Federal focal point.

The Center should:

1. Develop an effective consortium composed of such organizations as national voluntary health agencies, professional associations, insurance companies, business, industry, labor, agriculture, civic groups, foundations, educational institutions, communications media, and consumer groups.
2. Encourage pioneering approaches to local health education efforts, especially in voluntary health agencies, industry, consumer groups, and communications media.
3. Stimulate long-term and short-term studies about factors influencing health behavior—building on existing knowledge in the fields of education, communications, and behavioral science.
4. Conduct and stimulate cost/effectiveness analyses of most promising health education approaches in various settings.
5. Conduct and stimulate activities that increase the supply and improve the preparation and utilization of health education specialists, and that develop educational skills of other health workers.
6. Establish a system for collection, critical review, storage, and rapid retrieval of significant documents and information related to health education.
7. Promote sound educational practices in health programs through consultation, training, and materials.
8. Stimulate development of local health education centers.
9. Continually evaluate the Federal Government's health education activities and recommend needed improvements.

To insure a sound approach to the establishment of the Center, funds should be provided to an appropriate organization to investigate such matters as alternative methods of organization, short- and long-term financing, continued support, and working relationships with Federal health efforts.

IMPLEMENTATION

The Society for Public Health Education urges the President of the United States, Congress, the Department of Health, Education, and Welfare, the National Health Council, and others to exert leadership in implementing the above recommendations. The Society, which includes among its members the leaders in the field of health education, stands ready to provide consultation and support for the recommendations outlined in this paper.

Adopted by the Board of Trustees, Society for Public Health Education, Inc., November 4, 1973.

Mr. PREYER. Thank you very much, Dr. Ware, and we are particularly appreciative of the suggestions and comments from the Society for Public Health Education.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman. The gentlelady has made a very comprehensive, good statement and I have no questions.

Mr. PREYER. Thank you.

You have raised a point that health education is not defined in the bills. Should it be defined in the bills or do we run a risk that we set something in concrete that might turn out to be wrong later on.

Dr. WARE. I think that is a good question. Our concern really is based with the language of the bills in terms of what they talk about doing in health education, which seems to be very heavily emphasizing the dissemination of health information as the way to achieve health education of the public. I would be less than the professional I am if I did not say that for us the dissemination of information is only one aspect of what we consider to be the range of things that should be done as health education, whether such things are done by a professional health educator or any other professional in the field of health care.

Mr. PREYER. Do you have a definition of health education that you would like us to consider.

Dr. WARE. I think that the definition that has been adopted by the President's Committee on Health Education which was in its report, or else the definition that was used in the Fogarty Center Task Force on Preventive Medicine which I think essentially is the same definition as used by the President's committee; this definition emphasizes consumer health education, but includes the wide range of what should be considered as part of consumer health education.

Mr. PREYER. Fine, thank you very much, Dr. Ware. We appreciate it and I hope you make your airplane.

Our last witness for this morning is Homer P. Hopkins, Ph. D., a member of the executive board of the American Public Health Association and assistant commissioner for policy planning, Tennessee Department of Health, accompanied by Sigfried Deeds, associate professor, Public Health Administration, Health Services Development Center, Johns Hopkins Medical Institution.

Mr. Hopkins, you may proceed in any way you see fit.

STATEMENT OF HOMER P. HOPKINS, Ph. D., MEMBER, EXECUTIVE BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION, ACCOMPANIED BY SIGFRIED DEEDS, M.P.H.

Mr. HOPKINS. Mrs. Deeds and I are appearing before you today representing the American Public Health Association. APHA has 50,000 regular and affiliate members encompassing a broad spectrum of health and health related disciplines who provide many of the health education services that we are discussing here today.

Gentlemen, you have our written testimony for the record. I think that in order to present this fully, it would take some 20 minutes or so and with your permission I would like to summarize and highlight some of our comments about the specific legislation and take about half that time.

So I will be skipping around some.

Mr. Preyer. Without objection the full statement is made a part of the record. [see p. 276].

Mr. Hopkins. Thank you.

In the past, in preventing and controlling diseases, we could do things to and for people such as immunizations and the fluoridation of water supplies. We are now confronted by problems such as heart disease, hyptertension, cancer, and others whose prevention and control are dependent upon the behavior of the individual himself.

Furthermore, we do not at this time understand fully the nature of health motivation and how individuals choose between health promoting and illness promoting behavior.

As Victor Fuchs the eminent economist said in his book, "Who Shall Survive," the greatest current potential for improving health of the American is to be found in what they do and do not do to and for themselves. Examples he cites are individual decisions about diet, exercise, and smoking and collective decisions affecting pollution and other aspects of the environment.

In any discussion involving the types of services to be included in a preventive package, health education is always included and considered to be an important component not only in and of itself but as a means of assuring the effectiveness of the other aspects of the preventive program.

Health education has been underutilized and chronically underfunded for years. It, therefore, is underdeveloped and cannot spring full blown into the health care arena fulfilling unreal expectations.

The sort of developmental staging that is required is supported under the provisions for research and demonstration of H.R. 8278 as well as the testing and evaluation of model programs. We feel that the 3-year leadtime for application is much more realistic than is contained in some of the other bills that have been introduced.

The words "Health Education of the Public" are emerging in Federal legislation such as the HMO Act and National Resources Planning and Development Act of 1974. Implementation through promulgation of Federal regulations, however, has not yet taken place. We are very encouraged by the definitive and positive efforts in H.R. 8278 to develop standards for health education.

We will move out of the dilemma that I mentioned just a few minutes ago, in this bill by setting consistent national policy for health education, by codifying what is already known in the field, by setting guidelines and standards for demonstration and operational programs and their evaluation, and by research into applied behavioral change.

We have too often adopted a somewhat scattergun approach and have been left with a number of valuable but noncoordinated innovations in health education. Such programs as neighborhood health centers, family planning and some of the federally-supported manpower training efforts are examples of important but separate efforts in developing and offering a health educational component. Section 1702 "Federal Program" provides the focal point for needed coordination at the national level. We endorse the stronger mandate to the Secretary for monitoring Federal legislation, programs, and actions.

Earlier this year when Mrs. Deeds and I appeared before Senator Kennedy's committee to testify on his bill, we stressed at that time that we felt that the National Center or Institute whichever it is called, it is called different things in different bills, the Federal entity in health education, should be placed at a higher level in the Department of Health, Education, and Welfare and we still support that statement. We feel like it probably should be under the direct supervision of the Assistant Secretary for Health.

We need to step back and assess the state of the art to date. Much has been learned and we have to determine where gaps still exist and where some present health education efforts require expansion and further modification and refinement.

The support required for demonstration efforts that build on past successes is included in section 1713 "Community Programs." These efforts should not be confined to expanding our health delivery settings but should be viewed in a much broader sense both in terms of where these services are required and what should be included in their content. For example, health education must not be confined to the health care setting such as doctors offices, clinics, and hospitals but should be offered a variety of locations including schools, churches, community organizations, social clubs, and places of business. One concern that we have is that health departments, as major providers of health services, are not mentioned in H.R. 8278. Services offered in these different localities require divergent approaches to delivering health education and different types of manpower. The content of health education services varies as our knowledge of how our environment works and behavior affects our health status. Although efforts to date certainly have made some strides in these areas, we still have a great deal to learn and do, particularly in regard to educating our citizenry about environmental and occupational health hazards.

These demonstrations should be funded at a sufficient level over a long enough period to maximize their possibilities.

Too often demonstration projects, because of the inadequate funding or short duration, are never able fully to materialize and thus while money might have been saved, the net result is somewhat counter-productive. We thus recommend that funding of programs be stipulated for adequate periods of time.

H.R. 8278 addresses itself to a balance between research and the demonstration and evaluation components. We recommend that the law specify that research can go forward only in conjunction with service programs. This would have the effect of enhancing research in methods, procedures, and effectiveness rather than just in content areas.

In linking research efforts with service programs it is imperative as well that the service programs can provide feedback to the research setting of the field testing. The national surveys mandated in the bill ought to be carried out. The National Center for Health Statistics surveys is an example of research that should include health education practitioners and teachers in their planning and development in order that the findings will be utilized once the surveys are completed.

Let me repeat that point. We feel strongly the surveys to be carried out by the National Center for Health Statistics should have participation by health education practitioners in the planning and development of these surveys so that the findings will be used once the surveys are completed.

We would recommend more specific development of a health education manpower component within the bill. We support the pluralistic efforts to develop health education skills in all health professions along with the need for in-depth educational specialists with behavioral science and education backgrounds.

In addition to enhancing the curricula of professional schools, we would recommend inservice and continuing education for those already in the field and for people who, though not directly in the field, are in a position to provide services, some of these I mentioned a moment ago, groups such as school teachers, guidance counselors, industrial hygienists, clergy, community organizers to name a few. Many indigenous community workers although not trained in health education techniques can often be extremely effective in relating to individuals and their communities and thus in conveying information.

The question of how best to finance health education services has been pondered in recent years. There is strong temptation to consider the notion of using health insurance as the primary mechanism for paying for health education services. Many health education services, however, are provided in settings which do not lend themselves to health insurance payment mechanisms, such as home, schools, work places, and community organizations and agencies. One of the research areas that needs to be addressed is the continued financing of health education services provided outside of the medical care setting.

Currently we urge well marbled beef upon the public and at the same time pitch health education efforts to low cholesterol diets, we reconcile smoking cessation programs with subsidies to tobacco growers and we emphasize prevention and then push for legislation which encourages through funding, inpatient or catastrophic care. At the level of policymaking within this committee's purview, you have recognized these contradictions and have given the Secretary authority to identify Federal legislation, programs, and actions not in the interest of public health and to take action to change them. APHA commends this very forward stand.

I am now to the last two paragraphs on page 9. In summary, we approve the stronger mandate to the Secretary for monitoring Federal legislation, programs and actions, the 3-year lead time for development of standards for institutional health service providers and the emphasis on research, demonstration, and evaluation. We also urge the inclusion of stronger emphasis on manpower development and training, the inclusion of practitioners in applied research and a stronger role for health departments. In addition, we question the entility of specifying publications and information and would recommend that these methods be left to the discretion of the Secretary after further evaluation. Dr. Ware, in her testimony, went into a good bit of detail and very strongly emphasized the point we are making here about specific publications for health education of practitioners as well as for the public. There are already a number of them. Some of them very good and we are saying we should take a look at these and see if they should not be supported rather than coming out with new publications.

Also we go on record as supporting the plan for decentralized health education centers and the emphasis placed upon truth in advertising, particularly related to health insurance policies and drug labeling.

Gentlemen, we appreciate the opportunity to share some of our thoughts with you on this important and timely subject. We commend your subcommittee for taking such prompt action and for its deep understanding of the issues.

Mrs. Deeds and I will be pleased to answer any questions that you may have and we offer the assistance of APHA in any of your future deliberations.

[Mrs. Hopkins' prepared statement follows:]

Statement of E. P. Hopkins, Ph. D., Member, Executive Board, American Public Health Association

The American Public Health Association supports specific federal investment in health education of the public and the establishment of such as an area of federal health priority.

Changes in the levels of health of our citizens now appear to depend increasingly on complex societal and individual actions rather than on new infusions of funds for medical care or technology. Victor Fuchs, the eminent economist, in his new book *Who Shall Live?* concludes that present differences in health levels are usually not related to differences in medical care so much as to socioeconomic and cultural variables. He states, in this thoughtful book, that "there is no reason to believe that the major health problems of the average American would be isgnificantly alleviated by increases in numbers of hospitals or physicians although that may be altered by new scientific discoveries. The greatest current potential for improving the health of the American people is to be found in what they do and don't do to and for themselves." Examples he cites are individual decisions about diet, exercise, and smoking, and collective decisions affecting pollution and other aspects of the environment.

The need for an increase in preventive services is well-documented. In any discussion involving the types of services to be included in a preventive package, health education is always included and considered to be an important component not only in and of itself, but as a means of assuring the effectiveness of other aspects of the prevention program. For example, the establishment of a regimen for a hypertensive individual will be more easily accepted and followed by that person if he or she understands the reasons for the regimen. Also, the need for health education is not confined to specific groups in society such as the poor or the elderly, but is, rather universal. One only has to look in the shopping carts in both inner city and suburban supermarkets to see the soft-drink and snack filled grocery carts. If we are to attempt to control the costs of health care; and if we are to help our population become more active both in maintaining their own health and in understanding and better utilizing the system, we must assure that health education is a fully accessible and maximally effective component of prevention and, indeed our health care system.

Health education has been underutilized and chronically underfunded for years. It therefore is underdeveloped and cannot spring full blown into the health care arena fulfilling unreal expectations. The sort of developmental staging that is required is supported under the provisions for research and demonstrations of HR 8278 as well as the testing and evaluation of model programs. We feel that the three-year lead time for application is much more realistic.

The words "health education of the public" are emerging in federal legislation, the HMO Act and the National Resources Planning and Development Act of 1974. Implementation through promulgation of federal regulations, however, has not yet taken place. We are very encouraged by the definite and positive efforts in HR 8278 to develop standards for health education.

We will move out of this dilemma in this bill by setting consistent national policy for health education, by codifying what is already known in the field, by setting guidelines and standards for demonstration and operational programs and their evaluation, and by research into applied behavioral change.

The issues we consider in various legislative proposals for health service cannot be dealt with simply through the inclusion of health education as a service provided by those programs. Questions such as: Through what modes can health education best be offered? What kinds of manpower will be needed? and, What methods of financing will be required? are all considerations that must be dealt with if the health education component of any program is to be effective. We have too often adopted a somewhat scatter-gun approach and have been left with a number of valuable, but non-coordinated innovations in health education. Such programs as neighborhood health centers, family planning, W.I.C., and some of the federally supported manpower training efforts are examples of important, but separate efforts in developing and offering a health education component. Section 1702, "Federal Programs," provides the focal point for needed coordination at the national level. We endorse the stronger mandate to the Secretary for monitoring Federal legislation, programs, and actions.

We need to step back and assess the state-of-the-art to date. Much has been learned and we have to determine where gaps still exist and where some of present health education efforts require expansion and further modification and refinement. The support required for demonstration efforts that build on past successes is included iin Section 1713, "Community Programs." These efforts should not be confined to expanding our health delivery settings, but should be viewed in a much broader sense both in terms of where these services are delivered and what should be included in their content. For example, health education must not be confined to health care settings—i.e., doctor's offices, clinics, hospitals—but should be offered in a variety of locations including schools, churches, community organizations, social clubs, and places of business. One concern that we have is that health departments, as a major provider of health services, are not mentioned in HR 8278. Services offered in these different locales require divergent approaches to delivering health education and different types of manpower. The content of health education services varies as our knowledge of how our environment, work and behavior affects our health status. Although efforts to date certainly have made some strides in these areas, we still have a great deal to learn and do, particularly in regard to educating our citizenry concerning environmental and occupational health hazards.

These demonstrations should be funded at a sufficient level over a long enough period of time to maximize their possibilities. Too often demonstration projects, because of inadequate funding or short duration, are never able to fully materialize and, thus, while monies might have been saved, the net result is somewhat counter-productive. This is particularly important when the ultimate goal is one of behavior change. Five to seven years is often quoted as time required for community impact and change and we would, thus, recommend that funding of programs be stipulated for adequate periods of time.

HR 8278 addresses itself to a balance between research and the demonstration and evaluation component. The need for research and a strong theoretical framework are critical. However, this research should begin in the application of already know social sciences and should not be separated from the operational world in which it will be utilized. We would therefore recommend that the law specify that research can go forth only in conjunction with service programs. This would have the effect of enhancing research in methods, procedures, and effectiveness rather than just in content areas.

In linking research efforts with services programs, it is imperative as well, that the service programs can provide feedback to the research setting of the field testing. The national surveys mandated in the bill are examples of research that should include health education practitioners and teachers in their planning and development in order that the findings will be utilized once the surveys are completed.

We would recommend more specific development of a health education manpower component within the bill. We support the pluralistic efforts to develop health education skills in all health professions along with the need for in-depth educational specialists with behavioral science and evaluation backgrounds. Both of these tracks require specialized training and require funding support. In addition to enhancing the curricula of professional schools, we would recommend in-service and continuing education for those already in the field, and for people who, although not directly in the field, are in a position to provide services. This might include such groups as school teachers and guidance counselors, industrial hygienists, clergy, community organizers, to name a few.

APHA has been active in the field of accreditation of schools of public health and graduate programs in community health education where, heretofore, most community health education specialists were trained. We see the need for certification mechanisms for other institutions specialising in community health education as well, but certification, should not serve as a barrier to the utilization of a wide variety of personnel in the provision of health education services.

Although we have seen great strides in the variety and effectiveness of health manpower providing health education services, we have raised a number of problems as well. The proliferation of manpower has created gaps, overlap, duplication and conflict among health education personnel, both professional and non-professional. Certainly greater effort has to be placed in the area of certification of this manpower, but we must also gain greater perspective on how we can best utilize all personnel and to coordinate such pluralistic efforts. The nurse, for example, represents a valuable resource in the provision of health education services. Yet, there are still many gaps in our knowledge as to how she might be best utilized and what kinds of training are necessary to assure her maximum effectiveness. Also, many indigenous community workers, although not trained in traditional health education techniques, can often be extremely effective in relating to individuals and their communities and, thus, in conveying information. This is a valuable resource that must be continued and expanded, and more intensive work and coordination is necessary to maximize the effectiveness of such workers, protect their jobs, and generate the kinds of relationships with other personnel involved in health education so as to lead to cooperation and less conflict. Although some local efforts have been successful in this area, a great deal more coordination and support are necessary nationally in order to deal with this.

A specific career developmental plan, at all levels, from high school graduation through graduate training in the specialized field of community health education is also necessary to more effectively order the system and to assist the individual working in it. This plan should be consorant with the new kind of health manpower now being trained and should spell out appropriate professional competencies at every level.

The question of how best to finance health education services has been pondered in recent years. There is strong temptation to consider the notion of using health insurance as the primary mechanism for paying for health education services. Many health education services are provided in settings that do not lend themselves to the health insurance payment mechanism, such as the home, schools, the work place and community organizations and agencies. One of the research areas that needs to be addressed is the continued financing of health education services provided outside of the medical care setting.

Currently we urge well-marbled beef upon the public and, at the same time, pitch health education efforts, to low-cholesterol diets; we reconcile smoking cessation programs with subsidies to tobacco growers; and we emphasize prevention and then push for legislation which encourages through funding, inpatient or catastrophic care. At the level of policy-making within this Committee's purview, you have recognized these contradictions and have given the Secretary authority to identify federal legislation, programs, and actions not in the interest of public health and to take action to change them. APHA commends this very forward stand.

In summary, we approved the stronger mandate to the Secretary for monitoring federal legislation, programs and actions; the three-year lead time for the development of standards for institutional health service providers; and the emphasis on research, demonstration and evaluation. We urged the inclusion of stronger emphasis on manpower development and training; the inclusion of practitioners in applied research; and a stronger role for health departments. In addition, we question the utility of specifying publications and information and would recommend that these methods be left to the discretion of the Secretary after further evaluation. We go on record as supporting the plan for decentralized health education centers and the emphasis placed upon the truth in advertising, particularly related to health insurance policies and drug labeling.

We appreciate the opportunity to share some of our thoughts with you on this important and timely subject. We commend this Subcommittee for taking such prompt action and for its deep understanding of the issues. I and Mrs. Deeds would be pleased to answer any questions you may have and we offer the assistance of APHA in your future deliberations. Thank you.

Mr. **Preyer.** Thank you. We appreciate a lot of good practical suggestions coming out of Tennessee and from Baltimore.

Mr. **Hopkins.** Mrs. Deeds is professor of health education at Johns Hopkins and is a teacher and researcher and she is very knowledgeable in this field.

Mr. **Preyer.** Any questions.

Mr. **Carter.** I might have but, must defer them because of the bells. We will have to answer a quorum call.

Mr. **Preyer.** I am afraid that the second bell means we will have to be on our way over there. I regret that we cannot benefit from Mrs. Deeds' background and learning here but because I have a luncheon engagement I am afraid I will not be able to come back after answering here and then we have a markup session this afternoon.

Perhaps we have some good meaningful questions that we need to know the answers to so we could ask Mrs. Deeds in writing and see if we can benefit that way from them.

Do you have something to mention particularly where we are way off the wrong track?

Mrs. **Deeds.** No: I haven't really except that I would emphasize the notion that knowledge is not sufficient for change of behavior which is really our whole approach in health education. We are working in the compliance area and our patients know already what they are supposed to know but they are still not adhering to the regimen so there is a lot more to health education than providing the initial information.

Mr. **Preyer.** That is certainly sound. My wife is always trying to get me to take tennis lessons. I tell her I know how to play better than I do right now. It is not just knowing but making it work.

Mr. **Hopkins.** If you do have other questions or you would like for us to clarify or expand on anything that we presented this morning, we will be glad to do this in writing.

Mr. **Preyer.** Thank you very much

We will adjourn until in the morning.

[Whereupon at 12:35 p.m. the subcommittee adjourned until 10 a.m., November 14, 1975.]

NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

WEDNESDAY, NOVEMBER 12, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. James J. Florio presiding [Hon. Paul G. Rogers, chairman].

Mr. Florio. The session will come to order.

Mr. Rogers has requested that I convene the hearings this morning and our first witness is James F. Dickson, Acting Deputy Assistant Secretary for Health.

Mr. Dickson, would you like to introduce the people who are accompanying you?

STATEMENT OF JAMES F. DICKSON III, M.D., ACTING DEPUTY ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL; HORACE G. OGDEN, DIRECTOR, BUREAU OF HEALTH EDUCATION, CENTER FOR DISEASE CONTROL; BILLY GRIGGS, DEPUTY DIRECTOR, BUREAU OF HEALTH EDUCATION, CENTER FOR DISEASE CONTROL; AND DALE W. SOPPER, ACTING DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH)

Dr. Dickson. Thank you, Mr. Chairman.

On my right and from the Department is Mr. Dale Sopper, our Acting Deputy Assistant Secretary for Legislation for Health. On my immediate left is Mr. James Bloom, the Executive Officer of the Center for Disease Control of the Department; on his left, Mr. Horace Ogden, Director of the Bureau of Health Education at the Center for Disease Control; and on his left, Mr. Billy Griggs, Deputy Director of the Bureau of Health Education at the Center for Disease Control.

We have a statement that we would like to present if you choose, Mr. Chairman.

Mr. Florio. Yes, please.

Dr. Dickson. Thank you.

Mr. Chairman, Dr. Carter, I am pleased to have this opportunity to discuss the provisions of H.R. 8278, the "National Health Education and Disease Prevention Act of 1975," S. 1466, which passed the Senate on July 20, 1975, and H.R. 5839. These bills would provide authority for a major new program related to health information, education and promotion. We have previously testified on those provisions which would extend authority for disease prevention and control programs, and which would revise and extend the authority for venereal disease programs.

In summary, Mr. Chairman, we oppose this legislation because we believe that the responsible and most effective course is to continue to build upon the initiatives now underway, both within and outside the Federal Government. These bills would be counterproductive to this effort by creating unnecessary and inappropriate organizational structures, program responsibilities, and health education activities.

HEALTH EDUCATION BILLS

The heath education provisions in title I of H.R. 8278 would add a new title XVII to the Public Health Service Act, entitled Health Information, Education, and Promotion. This title would authorize the Secretary of Health, Education, and Welfare to formulate and carry out certain national policies including health education of the public, covering a number of areas which impact directly upon many other agencies of the Federal Government.

It would provide for the establishment and organizational placement within the Department of a National Institute for Health Information, Education, and Promotion, which would have responsibility for conducting and supporting research, and community and information programs. The Institute would have a director appointed by the Secretary and be under the direction of the Assistant Secretary for Health. Appropriations for these activities would be authorized at $40 million for fiscal year 1976, $50 million for fiscal year 1977, and $60 million for fiscal year 1978. H.R. 8278 would also create a new National Council on Health Information, Education, and Promotion made up of 19 members to be appointed by the Secretary from the public and private sectors who have distinguished themselves in the health field.

The provisions of S. 1466 and H.R. 5839 are similar in that they would establish new organizational entities and provide large authorizations of appropriations.

An organization would be created within the Department under the principal health official. The bills would also establish an inter-departmental committee on health education and a publicly-chartered, privte nonprofit corporation with functions that would complement and be coordinated with the DHEW organization.

DEPARTMENT ACTIVITIES

The Department shares with the authors of H.R. 8278 the deep interest in helping to solve the health problems of the American people through a strong health education program. Within the past year we have undertaken major new initiatives in the health education field, paralleling in significant ways the initiatives proposed in this legislation.

Mr. Chairman, I shall not discuss in detail these activities, but merely mention a few highlights of the program which is now completing its first year.

First, we have been instrumental in the development of a National Center for Health Education based in the private sector. The Center for Disease Control contracted with the National Health Council to recommend the functions, structure and organizational nature of such a center, to identify organizations in the private sector that would benefit from the services of such an entity, and to provide reasonable assurance of ongoing support from private sources. The National Center is now a reality, with the first meeting of its board of directors held on October 1. With the National Center in existence, there is now a private sector focus which can complement governmental activities and perform functions which can more effectively be performed through private enterprise. Such a liaison is particularly important since the great bulk of health education is actually performed by and through private sector agencies.

With respect to health education programs within the Department, we have undertaken several major lines of activity.

One: An Intradepartmental Panel on Health Education chaired by the Assistnt Secretary for Health and made up of the directors of the agencies and offices of HEW concerned with health education, is undertaking the task of coordinating and consolidating the numerous health education programs in the Department. The panel has initiated interagency work groups to develop Department-wide policies and strategies for high priority areas such as research and evaluation, health education as a reimbursable benefit, and interagency programs for reaching special target populations such as the poor, the aged, children and youth, ethnic and linguistic minorities.

Two: Interagency reimbursable agreements are being used as a vehicle to attack problems common to more than one component of the Department. Two such agreements are already in affect, one between CDC and the Office of Education to work with the National Congress of Parents and Teachers in encouraging improved health education curricula in the public schools, and another between CDC and the National Cancer Institute to strengthen cancer education activities.

Three: The Bureau of Health Education at CDC has some 30 active projects to stimulate innovative approaches and methods in health education, directed primarily toward population groups in special need, such as ethnic and linguistic minorities, the urban and rural poor, children, the aged.

Mr. CARTER. What is the linguistic minority? What is the difference between an ethnic minority and linguistic minority?

Mr. OGDEN. By lnguistic minority, we are referring to primarily Spanish-speaking groups in various parts of the country for whom there are special health problems and for whom there has been inadequate attention paid in the past.

Mr. CARTER. Are they not an ethnic minority, too?

Mr. OGDEN. I suppose they could be considered so. The problem of communication is largely a linguistic one in this particular group.

Mr. DICKSON. Four: The Bureau is working with the health services delivery and health resources programs, at both headquarters and regional levels, to develop guidelines designed to help assure the effectiveness of health education efforts in health planning and health care activities.

Mr. Chairman, I have briefly cataloged several of the initiatives now underway. These initiatives closely parallel those proposed in the legislation we are considering today. The program is only 1 year old. Yet, in this formative stage it is already demonstrating that cooperation among agencies is possible, and that order can begin to be achieved in the diffuse and fragmented situation which characterizes health education in both the public and private sectors.

DEPARTMENT POSITION

We strongly oppose enactment of this legislation for a number of reasons. As discussed earlier, we feel the objectives of the bill are already being addressed under existing authorities.

Additionally, the approach proposed in H.R. 8278, H.R. 5839, and S. 1466 differs in one very fundamental way from that of the Department. Health education is an essential and integral part of virtully every program of the Department, including not only the six agencies comprising the Public Health Service but also many other agencies and activities both within and outside HEW.

To divorce this responsibility from the programs through the creation of a separate superimposed health education bureaucracy, such as that proposed in these bills, would diminish the effectiveness of the PHS and departmental effort. It would also inevitably increase duplication of activity, since the agencies and program mangers would feel compelled to continue some form of eductional activity related to their respective goals. Therefore, the strategy we have deliberately adopted for health education of the public is that each agency must retain and fulfill the primary responsibility for health education as it relates to that agency's basic mission.

Let me cite a few examples. As you know, Mr. Chairman, the National Heart and Lung Institute has recently undertaken a major nationwide initiative to reduce the toll of hypertension. It has been clear from the earliest formulation of this program that education of the public with respect to this disease must be a central element of this initiative. Accordingly, educational activities have been built into every stage of the program, and these educational activities have been linked closely, as they must be, with all other program elements—screening, diagnosis, referral for treatment, maintenance and adherence and so on—all based upon the scientific expertise existing in the Institute. This integral relationship between the program and its educational activities applies equally to other specific disease control efforts, whether it be cancer, alcoholism, the effect of smoking, venereal disease, or others.

Similarly, each health service delivery program has a clear mandate for health education of its constituency. Thus programs in maternal and child health, migrant health, community health centers, HMO's, and many others must of necessity perform health education in carrying out their mission. By the same token, health education is an inseparable element of consumer protection programs such as those of the Food and Drug Administration, of school health programs such as those of the Office of Education, and many others.

This principle of primary responsibility in the programs requires, however, that there be coordination across agency lines, consolidation of duplicative efforts, and a comprehensive Department-wide strategy providing direction and emphasis to health education. A preliminary survey of PHS and other HEW health education activities indicates very clearly unnecessary duplication of activities. There is evidence of competitive efforts which could be better coordinated to reach common target populations.

With the emphasis on coordination, we are developing a strategy for health education which will assure:

(1) That health education activities in each agency are related to and contribute most effectively to broader DHEW and PHS health education goals;

(2) That each agency and program define more precisely the health education component of its mission, and be accountable for this component;

(3) That research and evaluation of the effectiveness of health education activities be strengthened and that these results be systematically shared;

(4) That a data base on health education activities of the agencies and programs be established and maintained, and that information be continuously shared among the programs;

(5) That existing mechanisms be more fully exploited, and new mechanisms be developed, for interagency collaboration on health education problems and activities of mutual importance, with emphasis on reaching target population groups.

Mr. FLORIO. Sir, is that not in essence what the bill is attempting to do, develop new agencies for interagency, coordination?

Most of your remarks to this point have been directed against the thought that we should have a new element that is going to coordinate these agencies and now I just heard you say that we have to develop new mechanisms for greater coordination of the efforts going on within the Department.

Dr. DICKSON. Yes, sir. The point I am trying to make here is that we do not feel that it is purposeful and that it is duplicative and it will be increasingly costly to divorce the education function from the primary categorical disease function that may appear in one or another segment of the Department.

We have a focus that does provide consultative services as well as its own programs in the Center for Disease Control. It is also necessary for there to be an interdepartmental panel for health education that gives increased coordination overall to the individual health education activities that are tied to the categorical programs.

We feel that is necessary but, as I mentioned previously, the primary principle we are dealing with here is that we should not divorce the education function from the ongoing responsibility and accountability for the specific categorical disease problem.

Mr. FLORIO. Thank you.

Dr. DICKSON. That duplicative or overlapping agency activities in health education be coordinated and consolidated.

That one operating agency of the PHS be charged with the primary responsibility for coordinating the activities of the various agencies, providing technical assistance and consultation to other agencies, and fostering more effective and innovative health education methodologies.

The structure is already in place for carrying out these necessary activities as a result of the Department's initiative in establishing a Bureau of Health Education within the Center for Disease Control (CDC).

The organizational placement of the Bureau of Health Education in CDC was done after careful consideration of a variety of alternatives. We feel that it is imperative that the health education activity remain in an operational setting, rather than be recreated as a staff office appended to a high bureaucratic level. Among the operating agencies, CDC's role as the action agency primarily responsible for preventive health services, and because of its close ties with the States and communities, made it the appropriate point of placement. Health education is, above all else, a preventive instrument. Its point of impact is the family and the community.

The Department already has authority under section 301 of the PHS Act for these activities. Therefore, the proposed legislation would only add to an array of health education authorities throughout the Department. Much of what is provided in this legislation is already underway with a specific organizational focus in the Bureau of Health Education. It would be counterproductive to create a new categorical health education bureaucracy which would only lead to disruption, delay, and disenchantment both within and outside Government. Further, organizational placement of an activity by legislative mandate inappropriately restricts the Secretary's ability to fulfill his responsibilities, and results in unnecessary rigidities over time which are detrimental to the most effective program management.

In addition, the amounts authorized by these bills for health education activities are not consistent with the President's prohibition on new spending initiatives during these economically difficult times. Moreover, at least $85 million is already being expended for health education by this Department and the additional HEW expenditures authorized by these bills would be unnecessary and excessive.

Considerable resources outside of HEW also are already being devoted to health education of the public. What is needed rather than more Federal expenditures is coordination of the resources already in existence in both the public and private sectors.

Health education should be built into health programs, and health should be built into educational programs—through schools, media, community organizations, health professional organizations, and other suitable vehicles.

In addition to these general considerations which would make the enactment of these bills undesirable at this time, there are several sections of the proposed title XVII of the PHS Act in H.R. 8278 which require specific comment.

Clauses 2 and 3 of section 1702 call for the identification of Federal legislative proposals and Federal programs which are not in the interest of the public health and for recommendations regarding changes in these proposals and programs. This is an important, continuing responsibility of the Secretary and the Assistant Secretary for Health and goes far beyond the purview of any health education program. The recent development of the forward plan for health, for example, is one way in which this responsibility is now fulfilled. It could neither adequately nor appropriately be discharged within the framework of the proposed health education program.

Section 1703 would require, as a condition of Federal support for projects providing institutional health services under the PHS Act, the Community Mental Health Centers Act, title III of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1972, or title IV of the Drug Abuse Office and Treatment Act of 1972, assurances that standards for provision of health education to patients are met. Development of such standards is an integral part of the programs concerned. However, several years will be required to develop workable standards and the expertise and manpower in all health care institutions to meet such standards. Premature and rigid imposition of limitations and penalties would not serve the purpose of furthering effective health education programs, and would prevent the delivery of critically needed services to the mentally ill and to alcohol and drug abusers and addicts.

Section 1703 also would require the providers of institutional health services under medicaid to provide health education and information to all patients. The cost of providing the information would be reimbursable under title XIX, and no medical payment could be made for institutions not providing such health care information. In addition, States would be required to provide their residents with information on the costs and quality of medical care and insurance policies available in the State, or its title XIX payments would be reduced by 2 percent. Costs would be reimbursable at 90 percent under medicaid.

The Department strongly oppose these provisions, both on philosophical and practical grounds. Conceptually, there is no point to penalizing the medicaid program (and potentially medicaid recipients) for noncompliance with this proposed law, or to use title XIX to fund administrative costs. Medicaid is a Federal/State program to finance health care services for the categorically and medically needy. To link it with the National Health Education and Disease Prevention Act of 1975 in the proposed fashion could jeopardize those services to medicaid recipients.

Presumably, the medicaid State agencies would be responsible for monitoring compliance by States and institutions. However, the State agencies have neither the expertise nor the manpower to perform this function. Since this would be an added administrative burden, not directly related to the agencies' primary purpose (implementation of title XIX), the effectiveness of the State's compliance monitoring would be questionable. Finally, the costs to the medicaid program would increase because the bill provides for reimbursement to the States and institutions for the cost of providing the required information.

Several subsections of section 1714, "Information Programs," include functions inappropriate for health education programs. For example, the publication of a health education journal for the general public would be an extremely costly means of reaching any substantial segment of the population and would be particularly ineffective in reaching those groups in special need. In addition, such an effort would be duplicative of journals already being published by official agencies and private organizations. The proposal for a continuous monitoring functions for mass media advertising is already a function more appropriate to the regulatory agencies concerned. The evaluation of new activities and services designed to improve health would be more properly the function of other health agencies. Many of the new methods listed in section 1714, such as megavitamin therapy, acupuncture, and structural integration, are already under evaluation, or being considered for evaluation, by the Alcohol, Drug Abuse, and Mental Health Administration, the National Institutes of Health, or the Food and Drug Administration. It is part of each agency's function to disseminate its findings. As for the development of models and standards on the cost and quality of medical care, this goes far beyond the purview of a health education function.

In our view, these proposed activities would seriously hamper the ability of a health education program to deal effectively with its appropriate high priority responsibilties.

Secton 103 of title I of the bill would require each prescription drug to bear labeling stating the various names under which the drug is dispensed, and information relating to the purposes for which the drug is used, the proper storage and handling of the drug, and possible adverse effects resulting from the use of the drug. The Secretary is also required to permit physicians, licensed to prescribe and administer drugs, to order a pharmacist not to furnish this information when filling a prescription for a particular indvidual.

We share the belief that patient labeling for drugs provides potential benefits for consumers. Section 103 of the bill, however, is unnecessary since FDA has sufficient authority under the existing provisions of the Federal Food, Drug, and Cosmetic Act to require appropriate labeling information such as indications for use, adverse effects, and proper storage and handling. FDA has implemented patient labeling for oral contraceptives, has proposed labeling for IUD's and is presently developing a comprehensive program for patient labeling of drugs in coordination with industry, consumer, and professional groups.

In addition to being unnecessary, the patient labeling provisions do not require useful information and would overly burden agency resources. Listing the various names under which a drug is dispensed is both impractical and of limited value to the consumer. Meaningful aspects of a drug rather than excessively full disclosure. Implementing these provisions within the 2 years limit would severely disrupt existing agency programs by diverting essential resources.

SUMMARY

In summary, Mr. Chairman, adequate legislative authority already exists for all necessary health education activities, including our current effort to nationalize and coordinate the numerous health programs of the Department. Accordingly, we strongly oppose H.R. 8278, H.R. 5839, and S. 1466 as unnecessary, duplicative, and counterproductive to our efforts already underway.

That concludes my testimony, Mr. Chairman. I shall be pleased to respond to any questions you or other members of the subcommittee may have.

Mr. FLORIO. Thank you very much.

Before asking Judge Preyer and other members of the subcommittee if they have any questions, if I could just ask one question for clarification purposes.

You advocated at the outset of your remarks a greater injection of the utilization of the private sector in health education. You even went so far as to say health education should become more involved with free enterprise. Enterprise, traditionally, has been regarded as the area that involve the profit motive.

What happens when there is no profit to be made out of health education? Give me some specifics who it is you want to become involved in performing the functions of public health that you feel your Department should not be dealing with.

Dr. DICKSON. Yes, sir. When the President's Committee on Health Education came forth with its recommendations, one of its primary recommendations was that the matter of health education was most properly attended to by some concerted and combined effort between the private sector and the Federal sector and one of its major recommendations was that a national center on health education be established in the private sector to be made up of private interest groups.

A contract was let by the Bureau of Health Education for the purpose of pursuing this recommendation and to see whether in fact such a center could be realized as an entity in the private sector to interact with the proposed Bureau of Health Education at the Center for Disease Control. Through the past year the topic was studied, and on October 1 of this year, such an entity in the private sector was established.

It is the intention through the Bureau of Health Education, through contract mechanisms and the like, to interact and to bring about through that national center increased coordination between the programs that are run by the Government and those that might be influenced by the private sector.

I could give you an example of how that interaction might take place if you would like.

If the issue, for example, at some time in the fall was the immunization of children for a variety of diseases, it would be possible, by having the influence of the National Center for Health Education brought to bear with respect to advertising capabilities, to assure that advertising efforts in the private sector could be put in parallel with the attempts at immunization at the time the children were beginning school. Thus, it would be possible to develop complementary efforts, that would be synergistic, as opposed to the simple effort of the Federal Government in trying to get on with the immunization program. In an educational sense, the people in the community would be made more fully aware, by voluntary effort in the private sector that advertised the fact the Federal Government was trying to provide this for them and for their children.

Mr. OGDEN. Maybe I could cite some specifics. I think private enterprise and the private sector are not the same thing. We are talking in the private sector about, for example, the great voluntary health agencies and other kinds of agencies which are nongovernmental which carry on a great deal of health education activity, talking about the professional organizations, the American Medical Association, the American Hospital Association, nursing and various other health professional groups, universities and the academic community, the insurance industry as it relates both to health and insurance in general.

There is a great range of kinds of enterprises in the private sector that are conducting health education and it is this kind of group that the National Center is trying to pull together so that they are indeed accomplishing some common purposes. That is the kind of organization we are mainly thinking about.

Mr. **Florio.** My only point is obviously, if we talk about the private sector and the commercial private sector, then we are talking about people with a vested interest. The American Tobacco Institute could very well be very happy about becoming a participant in health education. They may have a different perspective as to what constitutes health education. But I think we have got to in a sense write off interests that are willing to become involved because we know very well they are going to be working in accordance with their own interest.

I think the most important consideration is who is going to take care of health education in those areas when there is nothing to be derived from it, neither profit nor a particular interest to be served.

We have a very high infant mortality rate in the urban areas and in some of our inner cities here. Who is going to take responsibility for the health education that is necessary to cope with problems such as this?

You talk about advertising. Well, the people that are going to be advertising in accordance with their own particular interest, whatever that may be. It may be a laudable interest. But all I am saying is that the Government, your department, hopefully, is the agency that should have the responsibility for working in the public interest as opposed to a private interest, and I am really somewhat unhappy to see that there does not seem to be an appreciation for the fact that you have a unique position, you have a unique responsibility and, therefore, it seems to me you should be in the forefront rather than attempting to get out from under the responsibility for health education, that you should be willing to bring in individuals with a particular ax to grind.

I will defer at this point and ask some questions later, but I wanted at the outset to indicate that we have a different philosophy as to what the appropriate health education role should be for a governmental entity as opposed to the private sector entity.

Judge Preyer.

Mr. **Preyer.** Thank you, Mr. Chairman, and thank you, Dr. Dickson. I can understand your reaction to this program, this bill, though I do not agree with it.

Dr. Elwood testified before us the other day and he pointed out that the Government generally does a poor job when it intervenes massively to try to get people to do something that is good for them.

This bill has certain overtones of "we are going to do good to people" which I can see could build a certain resistance to it, and also I think the idea that putting another regulatory agency on top of another regulatory agency is an idea that is unpopular these days. But it seems to me this one is more reorganizing than adding new layers.

What the bill tries to do, it seems to me, is to increase the tempo of preventive activity, health education activity, and send some signal that whatever we are doing right now in health is not working very well.

You are familiar with the statistics that have been quoted here many times—about 25 years ago we spent $26 billion, now we are spending $114 billion and nothing much seems to be happening except what some have called a crisis in medical care. And it seems to me we want to send some signal that it is time to see whether there is not some better approach, whether that does not lie in the prevention area. But what we are trying to do is come up with a signal on that rather than sort of doing business as usual with the cancer program and sending out pamphlets on cancer and others doing whatever they have been doing before.

Dr. Elwood points out, I think very wisely, that we do not know the answers to a lot of these things and maybe what we are doing we ought to stop doing.

One thing I think we need to do is find some answers.

Incidentally, he would agree with you, I think, on the medicaid situation, he says maybe we have not got to the point where we ought to coerce that much yet.

Let me ask you one or two specific questions.

On your objection to the 2-year deadline on the drug package insert for patients, I wonder if perhaps you have not misread the bill on that? In that you speak in terms of the 2-year deadline and what the bill says at the top of page 23, is that the amendment, subsection (a), shall take effect 2 years after the day of enactment of this act.

I think the intention of that, maybe it ought to be made clearer, is that the requirement does not take effect until after 2 years have elapsed. In other words, it does not set a final deadline.

If that is not what it says, maybe we ought to change it to make sure it says that.

Would that soften your objection to that provision which otherwise you seem to agree with, if that is not a deadline but says you cannot put it in effect before 2 years and sort of leaves it open ended beyond that?

Dr. Dickson. Well, I do not think so. I think the answer is at the bottom of page 17. It says that in addition to being unnecessary, the patient labeling provisions do not require useful information and would overly burden the agency's resources.

I understand the point you are making, Mr. Preyer.

Mr. Preyer. Well, I would think on that we could adjust, we do not want to put useless information on it, certainly.

Mr. Sopper. I think we are saying, Mr. Preyer, where a situation exists that it is important to get certain information about a drug to each and every consumer that uses it, we have authority to do that. A good example of this is in the area of oral contraceptives. You do not get a prescription now for oral contraceptives without getting a complete package insert which describes what the drug is to be used for, describes the adverse indications, and tells the individual what to do if certain things happen. In this area, for example, it has been determined by the advisory committees and the FDA that it is important that every consumer who uses an oral contraceptive know what the problems are associated with them. So we have gone to the extent of issuing with every prescription the full brochure which explains this, and we are saying we can do that if it is necessary. We just do not think that it is needed in every individual case to go into this great detail about a drug.

For example, someone who was receiving a simple antibiotic for a bacterial infection, it may not be necessary to have agency resources expended in providing a full insert about that drug.

Mr. PREYER. Well, would it not be useful to know that that drug should be kept in the refrigerator, for example?

Mr. SOPPER. Well, that is done now, I know from personal experience if a pharmaceutical has to be kept refrigerated, it comes usually labeled on the container that it has to be kept refrigerated; otherwise, it loses its effectiveness.

I think the FDA now requires labels on drugs that have to be stored in a special way in order to preserve them. One gets that information at the time of purchase.

Mr. PREYER. Well, it sounds to me like we are in agreement that useful information ought to be put on it.

What do you consider useful information that might be different from what we would include in the bill here?

Mr. SOPPER. Well, I think as we pointed out in the statement, for example, the listing of all of the names under which the drug is dispensed, I think there is some question about what the ultilization of that is and whether or not you have to have labels that would go into that kind of detail. Also, with respect to the detailed adverse effects on all drugs, it is questionable what the full discolsure information would accomplish, what effect that would have on the average consumer, whether or not it would be meaningful.

I think where we feel it is meaningful to provide information about a drug, as in the case of oral contraceptives, we are doing that, and we are requiring that that be done with every prescription.

Mr. PREYER. Well, it seems to me you are saying that you want some flexibility in there, there ought to be some flexibility and we ought to use common sense, and I think that is what we have in mind, whether a drug will give you a stomach ache if you take it regularly, common sense kind of answers.

Let me just ask one other question.

Could you describe for us your school health program? Formerly, I understand, it was in the National Clearinghouse for Smoking and Health; now it is run by the Bureau of Health Education; is that right?

Mr. OGDEN. Yes, sir. As part of the formation of the Bureau this past year the Clearinghouse for Smoking and Health, which was already a part of the Center for Disease Control, was incorporated into the Bureau in large part because it was a nucleus on which to build an effective health education program. They had been supporting the school health program you are referring to and a number of other educational activities which had an antismoking component, but which really were broadly based in terms of how people approach the decisions that will affect their health and this kind of thing.

The school health curriculum that you are referring to has been underway now for about 6 years under the sponsorship of the Clearinghouse for Smoking and Health and now the Bureau. Basically, it is an attempt to acquaint children of the fifth, sixth, and seventh grade levels with how the body works and with how the kinds of health decisions they are going to be facing can best be handled.

We have tried also to involve a lot of parents and a lot of other community people, in addition to the school health teacher, and perhaps a nurse in the program. So we hope there will be some carryover into the home.

The first few groups of students who were exposed to this curriculum about 6 years ago are now being studied and an evaluation is underway to see whether—now they are about seniors in high school—there are some detectable differences either in what they know about health as a result of being in that curriculum or how they are beginning to organize their lives in terms of smoking and this kind of thing.

The curriculum has spread from a vary few school districts to now somewhere around 200. About 150 of them have been generated through our support of training programs for teachers and school administrators who then go back to their own school district. Elsewhere, it has been picked up strictly without any support of ours at all and actually financed by the local areas. This is a fairly unusual kind of school curriculum. This experience represe nts a fairly fast diffusion, but as you know, it is very, very difficult to get a new idea in school health education across the country simultaneously. Each local district has its own decisions to make.

The contract that we currently have in force in cooperation with the National Congress of Parents and Teachers, is another kind of approach to the problem of trying to get better school health programs more widely distributed across the country. This effort is aimed at community awareness in the community leadership group and school administrator group, and so on, stressing that school health education is important and that more attention and more support should be given to it locally.

Mr. PREYER. So you have then in effect developed a model curriculum?

Mr. OGDEN. Yes.

Mr. PREYER. The kind which this bill would require?

Mr. OGDEN. Yes, sir, it is one model and it is a model that has proved very popular with the teachers and the communities where it has been tried out. We are just now beginning to find out whether it is a model that is really effective in terms of some of its long-range purposes.

There are lots of other models; there are lots of other ideas going on in school health education. We are in the process at the moment of bringing several of the different parts of HEW together to consider a very large-scale proposal that has come in from California which would propose a new curriculum at the junior high school level which might be tested out in Los Angeles. We have been talking to the Heart Institute and Cancer Institute to see if a consortium of agencies might be interested in trying to take a look at this one where one agency might not be able to do so alone.

In this procedure, we are serving as a broker for this kind of program. In this case, it is a school health proposal. We are slowly developing these models and we are now getting to the point where I think they can be tested. It is a slow process.

Dr. Dickson. I think also, in response to your question, through the curriculum you have developed, it is directed to grade school age.

Mr. Ogden. The basic curriculum is fifth, sixth, and seventh and a fourth grade unit is being tested this year and an eighth grade unit is now under development.

Dr. Dickson. It covers the selected piece.

Mr. Ogden. That is right.

Incidentally, this particular curriculum model is being tested for the first time this week starting in Sheffield, England. They sent a team of people over last summer to take a training course and see how it is going to fit into the British school structure with some adaptation.

Dr. Dickson. In terms of impact, it probably has related so far to 2 million students and affected some 500 teachers.

Mr. Preyer. When do you think you will get some results of your evaluation?

Mr. Ogden. The preliminary report is supposed to be in our hands very shortly, Mr. Preyer. However, there are only very few schools that were in the program the first year, so that most of the kids have not had a long enough range to begin to tell what happened. This first evaluation is going to be on a very small number of students and a couple of communities, and I do not think what we are going to get out of the first study will be very definitive. We are trying to do more followups on the districts that came into the program in the succeeding years. I would hope next year at this time we will have a pretty good idea that the Berkeley school model has accomplished.

Mr. Preyer. That would be interesting to get the results of that.

Dr. Dickson. I think it will be difficult, as he is saying, to measure results of a program like this. I think in general what we find with respect to the entire health education effort, one of the problems you come up against, is that the instrumentation we have to measure results are not specific. They are poorly defined, and one of the efforts that we are trying to make in parallel with trying to do specific program-orientated evaluation is to develop adequate methodology so after a period of time has passed and someone wants to know what the resources have produced, we may be in better position to give some reasonable answer. I think it is going to be a difficult task.

Mr. Preyer. Thank you very much.

Mr. Symington. Could I ask, the Bureau of Health Education has done a review, has it not, for all the various health education activities in the Department?

Dr. Dickson. Yes, sir.

Mr. Symington. Did you learn what is going on there?

Dr. Dickson. Yes; they are still in the process of getting it together to make some final comments, Mr. Symington.

Mr. Ogden. I could elaborate a little on that. We have found there is a tremendous amount of activity in a great many agencies directed toward the general purpose of health education. It has been difficult in a number of programs to isolate and define health education which takes place as an integral part of what the program does. In a maternal and child health center, or any of the health service projects, for example, health education is happening. But, it is awfully tough for the Health Services Administration to tell us how many dollars or how many man-years actually go into health education because it does fit into the rest of the program. So we found that our preliminary attempt to do a survey that would pin down dollars and that kind of thing produced a mixture of apples and elephants. We are trying to go back, agency by agency, to find out what is being done in health education. We are in the second round of the agencies now because we felt the first cut was not terribly meaningful.

Mr. **Symington.** We would want that all to be coordinated in some fashion, would we not?

Mr. **Ogden.** I think coordinated certainly to the degree that, first of all, all of the various agencies of the Department are aware of what the others are doing and can begin to reinforce each other and work together instead of competing for the same pieces of the action out in the field. It is coordination by information sharing and persuasion at the moment.

Mr. **Symington.** How long do you wait until you decide that you need to pull something back together again?

Mr. **Ogden.** It is beginning to happen now.

Dr. **Dickson.** Mr. Symington, I think that one of the efforts that we have made along these lines is the establishment of the Intradepartmental Panel for Health Education and the mandate of that panel. There are several sections to it. I could just comment on them briefly if you choose because it is a key piece to the Department's overall activities in this area and without it there, in fact, is no program, in the sense the Bureau of Health Education is essentially a sort of staff arm for that forum of discussion.

Mr. **Symington.** When was it established?

Mr. **Ogden.** About a year ago.

Mr. **Symington.** How long had programs, for which it now has oversight responsibility, been going on before it was established?

Dr. **Dickson.** For a long time. We had efforts in the behavioral science area; how long have they been going on?

Mr. **Symington.** Yes. In other words, did it take quite a while to decide to set up an intradepartmental panel?

Dr. **Dickson.** Yes, the sequence of events that I judge you know is that there was a Presidential study that suggested several mechanisms that would hopefully improve the situation with respect to coordination of health education within the executive branch. One of the recommendations was this panel, along with setting up of the Bureau and setting up, in the private sector, the National Center for Health Education——

Mr. **Symington.** Who chairs it and who are the other members?

Dr. **Dickson.** The Assistant Secretary for Health chairs the panel and it is made up of the heads of the six Public Health Service agencies, a regional health administrator, representatives of the Bureau of Health Insurance Office of the SSA, and the Medical Services Administration of the Social and Rehabilitation Service.

Mr. **Ogden.** And the Assistant Secretary for Education, Assistant Secretary for Planning and Evaluation, and a couple of staff officers. These are actually the agency heads that are the members.

Mr. **Symington.** I understand. Back in 1962, I was the Executive Director of the President's Committee on Juvenile Delinquency, consisting of the Secretaries of HEW and Labor, and the Attorney General. They had that committee a few years but they had never met and most of the work was done by people in the substrata. Then we learned that even within HEW there were three or four departments, the Office of Juvenile Delinquency, the Children's Bureau, and others, that competed with one another, seldom conversed, and fought for key personnel, and a lot of nonsense like that.

So I hope you would not run it like that or any other Federal effort.

Dr. DICKSON. No; I think I understand very well what you are saying. You are painting the picture the way the Federal Council of Science and Technology has often functioned; it is all there but nothing ever happens. From the point of view of the Assistant Secretary for Health, Dr. Cooper, this is a prime interest of his in the sense that it brings together concerns he has with respect to education and prevention of disease. Looking down the road, a good deal of the possibilities for containing costs in the long haul for health lie in this area as well.

Mr. SYMINGTON. We want to see that what you find actually exists, how many offices are doing something in an area, are they now all members of the interdepartmental panel, how are they represented there? The whole point is in this period of rising health costs, the more health education and preventive health we can come up with early on, the cheaper the process gets.

Dr. DICKSON. If you choose, we can provide something for the record, some material that indicates——

Mr. SYMINGTON. Yes.

Dr. DICKSON (continuing). What has been happening and it is directly responsive to your questions here.

Mr. SYMINGTON. That would be good. You said the review is not quite finished. Would it be finished in time to make this record or would you like to give us what you have?

Mr. OGDEN. We could give you what we have up to now, Mr. Symington, with the understanding that it is a fairly preliminary kind of survey and we are now going into it in greater depth.

Mr. SYMINGTON. Is the Chair amenable that we would accept whatever they have to submit for the record?

Mr. PREYER [presiding]. Yes. I think that would be very helpful to see what the material looks like before we order it printed in the record.

Mr. SYMINGTON. Yes, we do not want a lot of raw data.

Mr. OGDEN. It was be fairly concise in terms of summary, if that is what you would like.

[The following information was received for the record:]

DHEW HEALTH EDUCATION AND RELATED PROGRAM ACTIVITIES

PRELIMINARY INVENTORY

The attached tables of DHEW health education and related program activities represent a preliminary overview which is in process of refinement and analysis on a program-by-program basis.

It is intended to include those program activities directed toward educating individuals to protect their health and to make more effective use of the health care system.

Because health education activities are an integral part of many health service delivery programs and cannot readily be separately identified and quantified, budget estimates for this group of programs include all program funds, where available. Health education-related activities represent, thus far, an undetermined portion of these program resources.

Behavioral studies have been left out of this summary. We are in the process of gathering information on approximately $30 million worth of this research throughout the Department.

Three activities are currently in progress to refine these data so that they can serve as a useful base for program decisions to reduce unnecessary duplication of effort and combine Departmental resources more effectively for health education purposes.

First, the Intra-Departmental Panal for Health Education has requested each member Agency to develop and submit a detailed statement of its health education mission, activities and resources. These reports are now being received and reviewed by the Bureau of Health Education, and in many instances add substance and specificity to the preliminary survey findings.

Second, the Panel has established three inter-agency task forces dealing with health education problems of special urgency: research and evaluation related to health education and health behavior; health education needs of special target populations; and issues related to patient education as a possible reimbursable benefit in health insurance programs. These task forces will present to the Panel in March 1976 their assessment of Departmental activity in their respective fields of interest, and recommendations for coordinated action.

Third, a program is under development to computerize the data on Departmental health education activities, to provide a readily accessible source of current information as a base for program development.

TABLE I.—ANALYSIS OF SELECTED PROJECTS BY DELIVERY SYSTEM [1]

Organization	Evaluation	School systems	Community organizations	Health care systems	Mass media	Out reach workers
PHS:						
CDC	3	10	20	26	12	8
FDA	0	1	8	0	6	15
NIH	2	0	2	14	0	3
ADAMHA	8	22	11	5	5	8
HRA	0	8	5	0	0	0
HSA	0	1	3	8	1	1
PHS, subtotal	13	42	49	53	24	35
OE	3	3	2	1	1	3
SRS: MSA						
SSA: BHI						
OASPE	3	0	0	1	0	0
OCA	0	0	0	0	2	0
OHD	0	0	3	0	0	3
Grand total	19	45	54	55	27	41

[1] This table is a "quick analysis" attempt to look at some of the outstanding categories of programs. Our continuing analysis will look at these and other factors in depth.

TABLE II.—ANALYSIS OF SELECTED PROJECTS BY TARGET POPULATION [1]

Organization	Black	Spanish speaking	Indian	Inner-city	Rural	Child/youth	Young adult	Mature adult	Aged
PHS:									
CDC	13	10	4	9	5	17	8	10	2
FDA	5	4	1	7		7	7		
NIH	7	1	0	8	3	0	2	12	1
ADAMHA	6	4	5	3	4	22	6	9	1
HRA	2	2		4	8	16	1	1	
HSA			2	2	1	2	4	2	
PHS subtotal	33	21	12	33	21	64	28	34	4
OE	3	3	3	3	3	2	1	1	
SRS: MSA									
SSA: BHI									
OASPE	1			1					
OCA									
OHD				9,445		8,368			1,077
Grand total	37	24	15	9,482	24	8,434	29	35	1,081

[1] This table is a "quick analysis" attempt to look at some of the outstanding categories of programs. Our continuing analysis will look at these and other factors in depth.

TABLE III.—IDENTIFIABLE HEALTH EDUCATION PROJECTS AND ACTIVITIES BY AGENCY
DHEW HEALTH EDUCATION AND RELATED PROGRAM ACTIVITIES

Organization	Number of projects [1]	Budget (thousands)
Public Health Service (PHS):		
Center for Disease Control (CDC):		
BHE	32	$2,574
BSS	274	10,141
Subtotal	306	12,715
Food and Drug Administration (FDA)	16	553
National Institutes of Health (NIH):		
NCI	18	1,955
N.H. & L.I.	11	1,798
Subtotal	29	3,753
Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA):		
NIMH	27	1,602
NIDA	36	3,830
NIAAA	23	6,563
Subtotal	86	11,995
Health Resources Administration (HRA):		
RMP [2]	394	21,775
Other	15	681
Subtotal	409	22,456
Health Services Administration (HSA):		
Indian health		1,963
BCHS (F.P. and maternal and child health)	14	1,044
Subtotal	14	3,007
PHS subtotal	860	54,479
Office of the Assistant Secretary for Planning and Evaluation (OASPE)	3	237
Office of Consumer Affairs (OCA)	2	225
Grand total	865	54,941

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[1] Projects represent a combined figure of program grants to States and staff activities. Budget figures represent estimates of funds for health education activities carried out as a part of those grants.

[2] RMP figures are now under in-depth analysis and refinement. This is the best estimate of the number of projects which are primarily concerned with health education of the public or which contain major educational activities.

TABLE IV.—DEPARTMENTAL PROGRAMS WITH SIGNIFICANT HEALTH EDUCATION COMPONENT NOT SEPARATELY IDENTIFIED

Organization	Number of projects	Budget (in thousands)
Office of education (OE):[1]		
School health and nutrition services	72	$900
Follow through	617	45,000
Adult education	10,000	68,000
Subtotal	10,689	113,900
Social and rehabilitation service (SRS):[2] Medical Services Administration (MSA)		
Social Security Administration (SSA):[3] Bureau of Health Insurance (BHI)		
Office of Human Development (OHD):[4]		
Head Start	8,368	430,000
Nutrition for elderly	665	100,000
Aging	412	96,000
Subtotal	9,445	626,000
PHS/Health Services Administration:		
Bureau of Community Health Services:[5]		
Community health centers	157	
Maternal and child health/sudden infant death syndrome	20	
National Health Service Corps	260	
Migrant health centers	105	

[1] Office of Education—These "projects" are the following major legislated activities of OE (fiscal year 1975 funds):

1. "Demonstration projects in school health and nutrition services for children from low-income families." Designed to improve school health and nutrition services for children from low-income families implementing a design for the early detection and removal of health and nutrition-related barriers to a child's optimum development.

2. "Follow Through health and nutrition services." Follow Through is a research and development program for disadvantaged children from low-income families designed to sustain and expand upon the gains made by children in Head Start. It is comprehensive in scope and directly focuses on all aspects of child learning and development: instruction, medical and dental health, nutrition, psychological services, social services, staff development and career advancement.

3. "Adult education program." In fiscal year 1974 over 10,000 local education agencies conducted public adult education programs addressing a broad spectrum of needs—social, economic, education—with activities to suit special groups: non-English speaking isolated, handicapped, institutionalized, veterans, older citizens. The rural areas around which units are built are: Health and safety, homemaking skills (food-clothing-shelter), the family and relationships within the family, etc.

[2] Social and Rehabilitation Service/Medical Services Administration (early and periodic screening, diagnosis, and treatment). The EPSDT program is a required service which all States must offer to persons under 21 who otherwise qualify under medicaid. Identification of such eligibles and the act of informing them of their entitlements and the availability of such services is required and is carried out to varying degrees in the States. Home health services, hospital and clinical care services are also mandated under medicaid and contain some degree of health education although extremely difficult to define under such circumstances.

[3] Social Security Administration/Bureau of Health Insurance—Beneficiary entitlements under medicare are sometimes confusing and difficult to explain. SSA concentrates its health education efforts on the dissemination of information to assist their constituency in proper utilization of the medicare system, and in response to inquiries through district offices as well as headquarters.

[4] Office of Human Development:

Head Start: Project Head Start provides some 379,000 disadvantaged preschool children with a comprehensive program of educational, social, psychological and health services. More than 10 percent of Head Start enrollees are handicapped children, many with severe handicaps.

Aging: The major development since April 1973 was the passage of the Older Americans Comprehensive Services Amendments of 1973. It provided for 2 new major program initiatives:

Title III: Strengthens the planning and delivery of services toward making social services available and accessible to older Americans in a comprehensive and coordinated fashion including health, continuing education, homemaking, counseling, housing assistance, and transportation.

Title VII: The national nutrition program for the elderly is designed to provide inexpensive, nutritionally sound meals to older Americans. In addition to promoting better health among the older segments of the population through improved nutrition, the program helps reduce the isolation of older people by offering them an opportunity to participate in community activities and to combine food and friendship.

[5] PHS/Health Services Administration/Bureau of Community Health Services—There are 157 community health centers receiving support. The health education component varies widely in method and level of activity. This is equally true in the 105 migrant centers. The in-depth review of these programs will give us a clearer picture of what health education is actually being conducted. HMO and EMS programs have only just begun to fund developmental programs. For example, 88 EMS developmental grants have been given to 35 States. Regulations require any HMO which receives Federal money to provide education for its membership. Our continuing health education program review will tell us the state of education as these new health systems enroll membership. Patient education activities at U.S. PHS hospitals go on as part of the routine in-patient and out-patient treatment. In 2 cases, the hospitals at Carville, La., and Staten Island, N.Y., staff is assigned the specific responsibility of health education. The Staten Island program has operated since 1967, is utiilzed by non-Federal activities as a model for consultation and is targeted to patients, employees and the surrounding community.

Mr. **SYMINGTON.** How many offices, what do they do, how much money do they get, and your judgment as to whether there is some overlapping or not. Have they been working separately or together?

Dr. **DICKSON.** We welcome this opportunity to make a composite statement in terms of what you are asking. We feel that the route the Department is pursuing is a worthwhile one and we are anxious to provide the material.

Mr. **SYMINGTON.** You see the reason this is important, of course. Everyone in the country wants to think that their tax dollar is being effectively spent and if we go back to our constituents and tell them that an agency of the Government does not even know what it is doing in this particular area or whether *it is duplicating, or overlapping,* it discourages the listener and we do not want to discourage too many people next year or even this year. We want Government to trim its sails; that is what everybody wants. You may find you do not need some offices.

Dr. **DICKSON.** We are looking for them and we know that they are there.

Mr. **SYMINGTON.** Maybe if you are looking for them you do not need them.

Dr. **DICKSON.** That is right.

Mr. **SYMINGTON.** One thing I noticed years ago is that there was very little communication between offices for fear that one would die, if you told too much about what they were doing it would show how much they were not doing, or how ineffective they were. You may be able to come up to this committee and say we saved you $1 million in the following way.

Dr. **DICKSON.** I think we have every reason, looking at the health enterprise as it stands within HEW, to feel that there is very much a need to trim sails and we intend that they shall be trimmed for the simple reason that it becomes apparent that some of the excess baggage gets in the way of implementation of the priorities you are setting. They are there and we intend to find them in a general sense, above and beyond this program.

One of the things that the Intradepartmental Health Education Panel provides us is a forum for discussion that brings out just these opportunities.

Mr. **SYMINGTON.** Thank you.

Mr. **PREYER.** Thank you, Mr. Symington.

Dr. Carter.

Mr. **CARTER.** Thank you, Mr. Chairman.

Some mention was made a few minutes ago about the use of the private sector volunteer agencies such as those involved in the American Cancer Society. This is a different type of private involvement. I am thinking of the American Heart Association, American Association for Cystic Fibrosis, American Arthritis Foundation, American Diabetes Foundation. I think that these people from the private sector would have no interest other than to do something about the diseases for which they were formed.

Do you agree with that?

Dr. **DICKSON.** Well, I do not know that that is necessarily so. I have had interaction with some of those groups, and I understand what you are saying. What their responsibilities are and particularly what their resources are dictate their opportunities to do things. I think there is hope within the National Center for Health Education that we will be able to pull some of these people together.

Mr. CARTER. That was my idea. You mentioned, I believe, the involvement of the private sector, and this is certainly a private sector that I would aim at.

Dr. DICKSON. Yes, sir.

Mr. CARTER. It would not have an ax to grind businesswise except to secure such educational benefits as were possible for prevention and education concerning the disease for which they were founded.

Dr. DICKSON. Yes; I think the orchestration of that in a combined effort is a difficult business. I think it is going to be more difficult in the sense that everyone's resources are constrained and organizations like that have to pay more attention to their prime purpose or else they have problems.

Mr. CARTER. And one of their prime purposes is education, is it not, and training?

Dr. DICKSON. Yes.

Mr. CARTER. All right.

Mr. OGDEN. Might I amplify a little on that?

I think we have had some experience with interagency cooperation among the kind of groups you are talking about, specifically in connection with the smoking problem. We have an Interagency Council on Smoking and Health that has included the Heart Association, the American Cancer Society, Lung Association, and a number of those groups. We have also found, I think, a lot of interest among voluntary agencies, not so much in joint projects as in the common feeling that there is a need for better methodology for how to do the health education job better, and I think they are interested in the development of the Center because they are interested in its being a source of expertise in getting this job done.

I think that is one area where they have a common interest.

Dr. DICKSON. Yes; I think along those lines one of the difficulties in terms of the educational aspect of their responsibility in terms of the educational aspect of their responsibility continues to be the problem of measuring the results of educational efforts. Because there is such a void, they are hoping the Center can pull together some of their interests and develop the methodology, the instrumentalities, which will help them measure what they are doing. These things would be universally useful to them.

Mr. CARTER. Personally, I think most of these groups, private and nonprivate groups, certainly do a good job of health education. They are of great assistance to those afflicted with the diseases for which these groups were organized.

On your interdepartmental health educational panel, why was this panel formed?

Dr. DICKSON. Why was it formed?

Mr. CARTER. Yes.

Dr. DICKSON. It was one of the recommendations of the President's Committee on Health Education. A period of time was given for the department to study the situation to see whether or not it might be a useful thing to do. It was felt that the health education effort required, first, a forum for discussing what was going on; and second, a group that could respond to the Assistant Secretary of Health and to the Secretary so that the overall health education effort of the Department would be more cohesive and effective.

I do not know whether that answers your question or not?

Mr. **Carter**. In a sense, it does. It was formed in response to the study of a Presidential Commission.

What were the other recommendations of that Commission?

Dr. **Dickson**. There were two other recommendations. One was that there be established outside the Government in the private sector a National Center for Health Education, and the other recommendation was that there be established a Bureau of Health Education.

Mr. **Carter**. A Bureau of Health Education?

Dr. **Dickson**. Within the Center for Disease Control.

Mr. **Carter**. Within the Center for Disease Control?

Dr. **Dickson**. Yes.

Mr. **Ogden**. The President's Committe report was not that specific. It recommended a rational center in the private sector and a focus within the Department of Health, Education, and Welfare, for health education activity. Subsequently, a task force, appointed by the then Assistant Secretary, Dr. Edwards, developed a recommendation for the creation of the panel and the Bureau in response to the HEW focal point concept.

Mr. **Carter**. A Bureau in the private sector and a panel within HEW?

Mr. **Ogden**. Well, a panel and a Bureau within HEW, and then further exploration of the development of the private center concept, which is what we did.

Mr. **Carter**. Private center or private bureau, which?

Mr. **Ogden**. The President's Committee recommended a National Center for Health Education, based in the private sector.

Mr. **Carter**. Yes.

Mr. **Ogden**. And a focus within the Department for health education. The task force that studied the President's Committee report and recommended some actions to Secretary Weinberger, recommended that the President's Committee recommendation for a focal point within the Department be responded to by the creation of the Bureau at CDC and the development of this intradepartmental panel which would give the Assistant Secretary direct involvement with the other agencies.

The task force recommended further that there be a developmental study done and supported by the Department to determine whether or not a national center in the private sector would really work, would it be useful, what should its composition be, and would it have sources of private support.

Mr. **Carter**. That was the second recommendation of the Secretary of HEW, Mr. Weinberger?

Mr. **Ogden**. That is right.

Mr. **Carter**. But the committee did recommend an organization of the private sector as well as one within?

Mr. **Ogden**. Yes.

Mr. **Carter**. NIH, and also one in the Center for Disease Control; is that correct?

Mr. **Ogden**. No; it recommended one in the private sector and one within HEW. It did not specify where in HEW?

Mr. **Carter**. This is where our legislation primarily is aimed at, those very two things. The things that the commission recommended, we are following those out. But you disagree now with the ideas promulgated by the committee; is that correct?

Dr. **Dickson**. I think the committee said——

Mr. **Carter**. You have to be fluid, and I think——

Dr. **Dickson**. The committee recommended that there be a focus of attention. When you set the focus, the question is whether you set it as part of the function of the categorical health activities within the executive branch or whether you step it aside and make it a separate administrative structure.

So I think the committee said make a focus. The study yielded the view that it would be better that the educational responsibilities remain with the programs that had categorical responsibility.

Mr. **Carter**. Yes, sir. What has your panel done, this interdepartmental health education panel?

Mr. **Ogden**. The panel has thus far considered and approved in general a health education strategy for the Department which is outlined in Dr. Dickson's testimony today.

It has also authorized the creation of three specific work groups which are now engaged in developing some specific proposals for three different priority areas in health education. One of them is research and evaluation related to health behavior; one of them is how do you do a more effective job of reaching some specific target populations that are in greater need of health education; and the third one deals with the problem of patient education in the medical care setting and whether or not it should be and in what form should it become a reimbursable benefit under insurance plans.

These three work groups are going to come forward to the panel with some very specific recommendations as to priorities.

For example, in research and evaluation, the agency's representatives on that subgroup are National Institutes of Health, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Education, Bureau of Health Services Research of the Health Resources Administration, and the Office of the Secretary, Office of Planning and Evaluation, with CDC.

What we are striving for in that work group will be a real definition of what kinds of research related to health behavior are being done by the various agencies, which areas of need exist that simply are not being touched by anybody, and then who has the most appropriate staff and competency and mechanisms to tackle those gap areas. There are things that mental health is already well into, and our hope is that instead of duplicating some work already being done, NIH and the Bureau of Health Services Research and others will take off on another segment. I think we are going to have a pretty good set of recommendations to come back to the panel. The panel will then have the power of discussing them and urging the various agency heads to accept these priorities into their research programs.

This is an attempt to identify within the Department not only what is happening, but also where are the gaps and which agency is best equipped to tackle that. That is the intent of the panel.

Mr. **Carter**. When do you expect the panel's report?

Mr. **Ogden**. On this particular one, we hope to have the report of the work group to them by February. The panel is meeting next week and then will meet again in February and we hope to have this research and evaluation report for the panel at their February meeting.

Mr. **Carter**. What has been the funding for health education and planning in HEW?

Dr. **Dickson**. You are asking the question, the entirety?

Mr. **Carter**. Yes, the total amount of money spent. I understand the funds are in different groups but I believe, using your words——

Dr. **Dickson**. In HEW?

Mr. **Carter**. Diffused and fragmented efforts, I believe.

Dr. **Dickson**. Yes.

Mr. **Carter**. The way you expressed it.

Dr. **Dickson**. Yes, sir; some $85 million.

Mr. **Carter**. Yes, sir; $85 million.

Dr. **Dickson**. Yes, sir.

Mr. **Carter**. Well, this legislation we have today would not be very much more than that, would it, $97 million in 1 year for that; is that correct?

Dr. **Dickson**. Yes.

Mr. **Carter**. All right, what are the goals and objectives of the Bureau of Health Education at the Center for Disease Control?

Dr. **Dickson**. We tried to put them down as succinctly as we could and have them adjusted to the immediate future.

I think the Center and the Bureau have six objectives.

Initially, I will make brief reference to them and I will go back as you choose.

There is a need at this time to generate a more useful data base on health education activities. That is one of our main concerns.

We are also intending to identify gaps that exist in health legislation with respect to health education, be they functional or legislative gaps, in the interest of having these filled.

A further objective is to provide more expert and timely consultation to the fragmented pieces of health education throughout the Department. This is to be done through the Bureau.

We also are intending to support a few innovative health education projects within the Bureau.

We are looking for other successful methods and mechanisms that will be more successful when broadly applied to health education in the interest of making it more effective.

And, finally, the intention in the immediate future, in concert with some of the other agencies, is to convene conferences on health education in the areas that have special urgency.

Those are some general overview intentions and objectives.

Mr. Ogden.

Mr. **Ogden**. Yes; I think perhaps our two strongest intents as a bureau at the moment and for the immediate future are two of the ones Dr. Dickson mentioned; first, to attempt to support through the contract mechanism some new kind of approaches to health education that show some promise of being replicable, capable of evaluation and usable across the country; and second, to attempt to pull together and provide some professional consultation in methodology related to health education.

The third one, which is largely internal, is continued development of a data base so that we can report reliably on who is doing what in the field of health education.

Those three, I think, are the central ones.

Mr. CARTER. I submit that in spending $87 million on these various projects, which have been called fragmented and diffused efforts, we may be wasting funds. I feel that it is time that we should do a study and try to coordinate. Really, I feel that the legislation that we have before us today would do that at very little more expense. Actually what you say here is more an argument for a National Center. When we get down to what you are doing, and the fact that your efforts, are, as you admit yourself, "fragmented and diffused," your testimony appears supportive of the legislation which is before us today.

Mr. FLORIO [presiding]. Would the gentleman yield?

Mr. CARTER. Yes, sir.

Mr. FLORIO. I concur with the remarks of the gentleman and would say in essence, what I have been able to perceive from your remarks is that you realize the need for greater coordination, evaluation, development of standard uniform methodology, but what you are doing is apparently looking to the panel to come up with recommendations to do that; and is it conceivable that this panel will recommend something akin to what this legislation talks about, the establishment of a coordinating entity within HEW for education?

Dr. DICKSON. I think not. The focus for action has been established in the Bureau of Health Education within the Center for Disease Control and that is the mechanism of choice.

Mr. FLORIO. When you accept the fact that there are these diffuse programs and what I perceive you are saying is that within the organizational operation of a particular area they should also be doing something about health education, not what you are saying, that there are different areas dealing with the operation of the program, the operational organization of the program, they should be also dealing with the medical educational ramifications of that program.

Does that not by definition mean your are going to have continuation of diffuse programs in different areas, and is there not some desirability to have someone who is going to make sure that the programs are not working at odds, with someone who is going to insure that there is sufficient standardized methodology to find out if the programs are doing what they are supposed to be doing?

Dr. DICKSON. Yes; but I think if you set up a separate administrative unit to do it, it will be costly and not very effective because you are then separating the educational function from the categorical responsibility. For example, there is a great opportunity with mothers, particularly, to educate them about the problems that children are having. This opportunity comes when the service that is delivering the care has the responsibility for trying to educate them, and to show them how they can more optimally make use of whatever health care delivery is available to them in their particular area.

I think an example of what I am talking about has to do with Indian health care.

Mr. FLORIO. Before they have to leave, I want to take the opportunity to recognize the presence of some eighth grade students from the Samuel Yale School in Stratford, N.J. They came down to see Congress in operation. They are going to have a tour of Washington and I did want to have them stand and be recognized by the subcommittee.

Thank you very much, we appreciate your stopping in.

Dr. DICKSON. I cite an example of the advantage of having an agency that has categorical responsibility also carrying out the health education function. I was mentioning an example from Indian health care. You could have the finest health care system in the world but if the Indian children who come in with running ears are not brought in at the right time, if their parents do not know how to make use of that system, it it not going to make very much difference in terms of their morbidity and mortality.

The opportunity for educating the parent with respect to bringing the child in at the right time so there are no complications, in some instances infectious disasters, is when the agency doing the treatment is also actively engaged in explaining to the mother in terms of health education for her when the child should come in, how the child should use that system.

Mr. FLORIO. Are we not talking about extremes? You are implying if you are going to have an agency, coordinating medical agency, that, therefore, there will be no communication, there will be a total separation, I think that was the word you used, between education and implementation of policies? Is it not that extreme position that really tortures the meaning of what this legislation talks about?

We are talking about the greater utilization of medical education in conjunction with the implementatoin of a program. We are not saying that they are going to have an agency that is going to do nothing more than talk about education, that is going to be totally removed and isolated from the organizational effort. What we are talking about is coordinating education and implementation.

I think in many respects most of your arguments are probably valid if in fact, the agency was going to be isolated somewhere totally removed from the implementation process, and that is not the purpose of the agency, as I read it. The purpose is to make more effective the interagency interaction.

Dr. DICKSON. Maybe you could tell me then, if I may ask——

Mr. FLORIO. Sure.

Dr. DICKSON. In the situation of the single Indian child with the running ear, how would your proposed institute act in that situation to provide to that mother?

Mr. FLORIO. Well, it seems to me, and I do not know the specifics of the particular problem, if in fact the question had something to do with nutritional deficiencies in the Indian diet, or had to do with too much smoking by Indians, it seems appropriate that there should be some entity that is going to coordinate the areas of smoking, the areas of nutritional needs, with the particular operational problem of dealing medically with the problem.

That is really what we are talking about, is making sure that there is coordination and consolidation of these programs.

Dr. DICKSON. Well, all right, I just say that as a physician, I have a feeling about that apart from my position, and that is taking care of people is a very interesting and difficult business at times. When you put the responsibility and the accountability together in the delivery of health, regardless of how you do it, whether it is medicine or surgery, functionally, you get a better result. If you tie that responsibility for the health education to the functional accountability with respect to a particular categorical disease problem, your chances of getting a result with respect to health education are just multiplied.

Mr. **Florio.** If I could conclude the point and then I will yield back Dr. Carter's time. Are there that many maladies that stem from one factor of causation so we can afford to treat medical education with regard to a particular problem in an isolated vacuum separated from other potential factors of causation? That is to say, if in fact we have got medical education with the operational program in a particular area, and we have it in another particular area, and the fact that the two areas happen to be related, and we have these two agencies dealing with their separate problem, is there not some desirability in having interagency coordination and should that not be a responsibility of someone who is separate and apart from the particular bias of the particular agency?

Dr. **Dickson.** Well, I think I agree with you that there is a problem with respect to fragmentation. We say that more coordination is needed and that a focus of responsibility for that coordination is required.

We have established that focus in the Bureau of Health Education but we do not believe that you take the educational function out of the categorical disease effort and set it as a separate administrative entity.

Mr. **Florio.** Thank you.

Mr. **Carter.** Thank you. Of course, you gave the instance of the youngster with the running ear. There is nothing health education could probably do about that. Possibly if the child had a warm home and had not been exposed to a virus or a bacillus of some sort he would not have had otitis media or a ruptured ear drum and the running ear that you mentioned. But we have made reference in this case more to the principle of educating our patients or the public. In the case of diabetes, concerning diet and so on, as far as this is concerned, health education does make sense.

As to how to live, proper diet, exercise, avoidance of too much alcohol, or any alcohol for that matter, it would be better, to teach good health habits.

We think that this is one of the purposes, at least, of this bill and we think that it is very much needed. But the very thing which you mentioned is one of those things which really health education possibly could do nothing about unless we found a vaccine for the common cold or for the bug which induced the infection.

Dr. **Dickson.** Yes, I think in some instances that is true. What I had in mind with the mother and the child with the running ear is that she needs to be told when she brings the child in that the time to bring the child in is not when the pus is running out of the head but rather when there is a pain in the side of the neck and there is early pain in the ear area. That is educating her about the nature of the disease process; it is educating her about how to use that system. I am saying the person that can really do it optimally and at the least cost is the person who is responsible and accounable for care.

Mr. CARTER. Who is accountable and responsible——

Dr. DICKSON. For the care.

Mr. CARTER. I think that is quite true, if he will do that.

Dr. DICKSON. I think what we are trying to do with our——

Mr. CARTER. That is entirely true because there is no question that he is better qualified to do it, but in so many instances he will not. If, the mother gets there too late with the ear already draining, of course, he can still treat the youngster but there might well be impairment of hearing.

Wha are the goals and objectives of the Bureau? I have asked that question.

How much money was appropriated for the Bureau last year and this year?

Dr. DICKSON. I believe in the neighborhood of $3 million.

Mr. CARTER. How much has been authorized for next year?

Dr. DICKSON. About the same.

Mr. CARTER. You do not anticipate any increase then?

Dr. DICKSON. Well, 1977 has not been determined yet for us.

Mr. CARTER. With respect to funding grants and contracts, what criteria have you established?

Dr. DICKSON. There has been particular attention given to the nature of the contracts and grants that would be supported by the Bureau. It was felt that, with the money restricted, they primarily would have to be innovative projects that showed promise not only in the area that they might specifically relate to but that they might have some rewards in other areas in health education.

I believe also that built into the proposals should be evidence that a real attempt was being made to develop methodologies for measurement of results after the moneys had been applied for a particular purpose.

Also, with the money being restricted, it is intended that the studies be conducted in population groups that have particular needs. In addition, we would hope that the methodology we support would be something that could be replicated and used, adapted to similar problems and used in other places after this initial study, without the necessity to infuse Federal funds to get the work done.

Mr. OGDEN. You have hit our major criteria. We want projects that are really trying some new approach. We want projects that can be evaluated and that are capable of being replicated by people in other communities without the constant infusion of more Federal money. As an illustration, we have a project underway now in cooperation with the Cooperative Extension Service of the State of Arkansas. The Agricultural Extension Service, as you know, is a very effective outreach system for getting to rural people. It has credibility; it has contacts throughout many States; it is one of the best systems.

In recent years, particularly in some States such as Arkansas, there has been an interest on the part of agricultural extension people in doing a better job of health education along with the other areas in which they are involved. Under regional medical programs, a small project had been started at the Arkansas Extension Service about a year and a half ago. We have undertaken a contract with them this year which combines a project in which the Agricultural Extension Service, the Department of Public Health and the University of Arkansas are all involved in a cooperative capacity. We are working in 15 different counties of Arkansas to see how the Home Demonstration agent or 4–H Clubs can be effective health education instruments, what kind of backup and communication do they need with the county public health authorities, with the private medical profession, with other sources of expertise, how can we really begin to use that agricultural outreach system as an effective health education channel the way it has been for some other things.

This is one example of the kind of project we are optimistic about, further because there has been a lot of interest now expressed in other States. It is possible that if we can demonstrate some results out of this one, a number of agricultural extension services around the country will begin to build similar models into their programs in the years ahead.

Mr. Carter. I think this is probably a good project. As you know, I believe, the motto of the 4–H Clubs is head, heart, health, and hands.

Dr. Dickson. Right.

Mr. Carter. And you might use that. But I would like to know, you mentioned Arkansas, what is the level of immunization in that State?

Dr. Dickson. The level of immunization now is quite high. I do not know exactly. A couple of years ago it was among the lowest in the country and the Agricultural Extension Service's first major project was indeed to conduct a major statewide campaign to improve the immunization status.

Mr. Carter. But we have gone down in our immunization percentage throughout the country in the past few years, is that not true?

Mr. Bloom. I believe it has gone back up in the past year. We can provide specific information.

Mr. Carter. I do not believe so.

Mr. Ogden. In Arkansas it went up from about the 40-percent to the 70-percent level as a result of a program in which the Agricultural Extension Service was one of the real leadership agencies in the State.

Mr. Carter. In Arkansas?

Mr. Ogden. Yes.

Mr. Carter. You did a good job there. I hope you can do it throughout our country.

Have you evaluated any of the health education programs funded by the Bureau of Health Education?

Mr. Ogden. They are just now really getting underway, sir. Since we are just completing our first year of existence, we have some evaluations built into the projects we are now supporting but none of them has run its course long enough to have any real results in as yet.

Mr. Carter. Yes, sir. Have you envisioned using, or do you use television to a great extent in your health education programs, or radio?

Mr. Ogden. In our direct programs in the Bureau thus far, we have not. A number of the departmental agencies have done so and one of the targets for our interagency analysis and recommendation is going to be how you can use mass media more effectively.

In the past it has been used, I think, very effectively by the antismoking programs of a few years ago, but they enjoyed a peculiar situation in that they were granted equal time to commercial advertising on cigarettes until commercial advertising was banned. The drug abuse and alcohol people have both conducted major programs in the past, the value of which I think is rather doubtful. Some studies have indicated that they were not terribly effective.

We are trying one approach where we are going to try, I think, initially with our smoking campaign this year, to get TV spots regionalized or localized rather than simply put in as a public service announcement to the world at large. We have evidence to believe if you have a local sponsor who is in touch with his local station manager you are much more likely to get favorable public service time. The usual experience with health spots in the past, public service announcements, has been that unless there is some special interest, they tend to show up at 7 o'clock on Sunday morning. They do not get into the prime timeslots when very many people are watching. We think by localizing them, by giving local identity to the health department or local agency, perhaps that will encourage them to work with the local TV and radio people to get them into more favorable timeslots.

This also, incidentally, is one area I think in which the National Center for Health Education in the private sector can be extremely helpful to us because some of the membership there is very closely associated with the media.

Mr. CARTER. Do you think the media will take that as public service, those public service announcements, or will you need more funds for that?

Mr. OGDEN. Well, they will have to be public service so far as the governmentally sponsored ones are concerned. We are not able to buy time on television.

Mr. CARTER. You meant to say something?

Dr. DICKSON. Well, a little tangentially.

As you get into radio and get into communications and technology with respect to it, I would like to add to what Mr. Ogden was saying by pointing out the Bureau has recently begun engaging in projects that directly serve patients or consumers, if you will, one way or the other. An example of this direct service activity has to do with a contract we have with the San Diego Medical Society and this activity has been, I judge, of particular interest to Mr. Waxman on your committee. A major component of this project is a consumer dial access system known as Telmed, and the project has several hundred English and Spanish tapes available, on a variety of high priority topics as far as preventable disease is concerned. Leadership and training in this modality is now being provided to people in other communities in the interest of their getting on with developing similar systems.

Mr. CARTER. I am quite familiar with some of the pamphlets you put out.

Do you think they are attractive, appealing, and would influence children and families?

Mr. OGDEN. Do you have reference to specific pamphlets?

Mr. CARTER. Put out by CDC, particularly, and HEW and NIH?

Mr. OGDEN. I think there is a great variety of them. I think one of the problems with health education in Government in the past has been that we have attempted to pamphleteer the world and I am not sure that that is really one of the most effective things we can do.

Mr. CARTER. I could certainly agree with you.

Mr. OGDEN. I think pamphlets are least likely to reach the people who need the information the most, because they tend to be rather lofty in their educational level. They tend to be rather difficult to understand. I think some pamphlets if used in conjunction with other parts of an educational program can be very, very useful. I think we could certainly improve the quality of what we have.

Mr. CARTER. For physicians in many cases, I think they are helpful; at other times I think they are not too appealing.

I will not ask the other question.

Thank you.

Mr. FLORIO. Most of your comments and criticisms have really addressed a few points in the bill. Can I take it from that that in the event this committee were to accede to your thoughts and make the appropriate modifications in accordance with your requests that the balance of the title will receive your support?

Mr. SOPPER. What we are saying, Mr. Chairman, is that we think we have a good program started in the Department in the health education area with the intradepartmental panel, with the locus of health education activities in the Bureau at CDC, and with the establishment of the national center in the private sector.

We do not think the passage of a statute is necessary to achieve an increased level of activity in the health education area.

Mr. FLORIO. In essence, you are opposed to not just the point you have raised, but you are opposed to the concept of Congress enacting any legislation dealing with medical education?

Mr. SOPPER. Health education; yes. We are saying we have taken steps administratively; we are using existing authorities which the Congress has given us to mount an effective program, and we do not see the need to establish a statute in this area.

Mr. FLORIO. Well, not to be too self-righteous. Go back to the Constitution. It is supposed to be the Congress that draws the broad guidelines of policy and then you implement.

You have already conceded the fact that up until this point that there are diffuse programs, the coordination has been lacking, and now what you are talking about, I will be quite candid, you are talking about having a panel that is working on some things, stepping into new areas in an attempt to coordinate, but there are those who suspect that the constant reference to the private sector, to involve the private sector is really more in accordance with the budgetary considerations of the administration, that we are talking about sort of shifting more and more out of the public sector, out of HEW, because we have not got money to do it.

You are talking about $3 million to coordinate the whole $87 million health education program.

It seems to me that is clearly inadequate and I suspect there are those who feel the budgetary considerations are determining what policy you are going to have with regard to health education and, therefore, I am not questioning anyone's good faith here but I think we have some suspicions that in fact, health education is not the high priority area that it should be within HEW and that when you start talking about national health insurance, well, we are talking about all sorts of things to cure people, but most people have come to the opinion that if we are going to really have impact upon health problems in this country we are going to have to do more with health education.

I saw something in the paper that came out day before yesterday, 85 percent of the cancers are environmentally caused. That in fine but we are going to have to go to education if we are going to deal with that problem. It is not sufficient to sit around and try to find ways of curing cancer after we detect it is there. I think the Congress and this committee feel very strongly the Congress should have more of a role in setting guidelines for health education and I appreciate your feelings. And some of the points that have been made I am not totally adverse to but I do not think it is appropriate to totally remove the educational function from an implementing agency, but I think you have conceded the point that much has not been done, and I think when we start talking, and the part that really offended me was the constant reference to getting the private sector, because if we are talking about private sector commercially we are talking about people with a vested interest. If we are talking about the private center noncommercially we are going to charity. With the economic situation we have, we are not going to get charitable nonprofit organizations coming up with the appropriate money, with the appropriate coordination, ability to really take the overall national picture into account.

So, I would hope that in the event that this bill does pass that we will be able to count on the cooperation of HEW to accept some of the philosophy that I think you have heard today, and that is to put a greater emphasis on the whole concept of health education than we currently see taking place in HEW now.

Dr. DICKSON. I think I might speak for Dr. Cooper, Assistant Secretary of Health, and indicate the extremely high priority of importance that he places on the task of preventing disease and the relationship of health education to it. You can be certain that we will take your comments back to him. He will be pleased to have them.

Mr. FLORIO. If I could conclude on one point. I notice in your comments you talk about the fact you do not think Health Education magazine is an effective vehicle for getting out information. I was wondering if you are aware of this magazine and why we are putting it out if it is not an effective vehicle, and what does it cost, if it is not, and why are we doing these things if you feel, as you feel apparently, strongly, this is not something that is desirable?

Dr. DICKSON. Well, I think we are talking about a principle, I mean, it is very much like the man who walks to the window and has a brick in his hand and opens the window and throws it out and the brick falls straight up.

Well, that is interesting but statistically, it is not very significant. So, I do not know how significant it is when you show me one magazine in terms of the principle we are talking about.

Mr. FLORIO. The principle is, I assume someone has made a value judgment that the magazine serves a purpose. If the magazine does not serve a purpose why are we putting it out? And obviously, it is one magazine, but the principle is that you feel utilizing magazines, and some reference was made to pamphlets. I share some of that thought that the people who most need these magazines and pamphlets are not the ones who are going to make use of it. That is clearly the case with regard to your inner city situation, with regard to some of your rural areas. I am concerned as to why we are still having magazines being put out. On the other hand, perhaps someone has made a decision that it is valuable and we may both be wrong in terms of questioning the value of the type of thing.

I suppose what I am saying, is this not what should be done by coordinating entities making some of these decisions as to whether this is valuable or not, and if that is the case——

Dr. Dickson. The answer is yes.

Mr. Florio. If we are having difficulties maybe that reinforces the argument this bill is making, maybe we do not know exactly what is going on, maybe we do not know whether we are achieving what we are trying to achieve.

Dr. Dickson. I think we are in agreement that there is fragmentation. We are in agreement that increased coordination is necessary and the difference relates to the administrative mechanism.

Mr. Bloom. Your suspicion about why we have discussed the private sector and the establishment or creation of the National Center for Health Education and your suspicions that these reflect budgetary or economic considerations, I believe, are unfounded.

We mentioned earlier on that the original White House committee gave as one of its recommendations that there should be such an organization created at Government instigation. At least, some of us at CDC were skeptical this was the way to go about doing this thing. Therefore, in our implementation of the recommendations of that committee, we first let a contract to study the feasibility of such an organization. We did not just automatically accept that it would and could be created and could and would serve a useful purpose. This was done through the National Health Council. It was shown to our satisfaction, and to the Department's, that this would be a useful facet in the total health education phase of delivery of health services, health care and prevention in this country, and not as a budgetary gimmick as a way of saying someone else can pay for it. It is out there now. Health education funds are being spent in one form or another in the private sector. The Center is an attempt to try to bring to that sector some degree of coordination, an improvement in the way funds are being spent in the private sector already.

Mr. Florio. Gentlemen, I would like to thank you for the time that you have provided to us this morning. I would like you to carry a message back to Dr. Cooper. I have the highest degree of confidence in Dr. Cooper. His coming to HEW has been one of the most important things that has happened to HEW and the health care policies that we are going to be evaluating and hopefully, implementing, so I am confident there is at least some voice within HEW that is sympathetic to some of the philosophies, some of the policies that the Congress, I think, is attempting to implement.

I thank you for coming.

The committee stands adjourned until 10 o'clock tomorrow morning.

[Whereupon, at 12:10 p.m., the committee was adjourned, to reconvene at 10 a.m. Thursday, November 13, 1975.]

NATIONAL HEALTH EDUCATION AND DISEASE PREVENTION ACT OF 1975

THURSDAY, NOVEMBER 13, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 334, Cannon Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. Rogers. The subcommittee will come to order, please.

We are continuing our hearings on the bills regarding national health education and disease prevention.

Without objection, the Chair wishes to place in the record, as though read, a statement from the Honorable Henry S. Reuss of Wisconsin.

STATEMENT BY HON. HENRY S. REUSS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. Reuss. Because Milwaukee was the first city to receive a rat control grant back in the late 1960's, I have maintained a continuing interest in the program's progress.

I am pleased to note that just a couple of months ago the Comptroller General of the United States, in an evaluation report, said that, even though rat control has encountered some problems, the program has achieved important gains during its brief history.

Among the benefits cited were:

A 54-percent reduction, from 710 to 330, in the annual number of confirmed rat bites in the 20 areas originally covered by the program;

A steady increase in the number of city blocks, to about 20,500 at the end of June 1974, where rat control was considered effective; and

Greater public and local government understanding of the rat problem and actions needed to solve it.

Therefore, I welcome this opportunity to propose to this Subcommittee on Health and Environment that, in its consideration of the funding authorization for section 317 of the Public Health Service Act, special attention be given to protecting grant money for the fight against disease-carrying rodents.

As you know, the Ford administration is downgrading the program, by reducing budget authority to $5.4 million for fiscal 1976. Instead of downgrading, however, I believe rat control funding should be preserved. This can be accomplished by stipulating that 37½ percent of the funds authorized for each of the fiscal year 1976, 1977, and

1978 to control communicable disease should be earmarked for rat control.

The bill you are considering would combine the rat control program with the overall campaign to control communicable diseases. Fiscal 1976 budget authority would be set at $35 million, and rise to $40 million in fiscal 1977 and $45 million in 1978.

By stipulating that 37½ percent of this budget authority be set aside for rat control, you will be insuring that the program will be maintained at the fiscal 1975 level, which totaled $13.1 million, and in fact will increase slightly each year.

Moreover, I recommend that the grantmaking criteria be perfected to remedy the program's major defect as cited by the Comptroller General's report; that is, the inability of cities to assume the financial burden of a declining Federal role in rat control.

I am aware that the program's original concept was for the Federal Government to provide "seed money" to help cities get their rat control programs underway, and that, over the 8-year life of each grant, the recipient community was supposed to assume an increasing share of the program cost.

Though I agree with the idea that, eventually, rat control should become a local effort, I feel strongly that, in practice, the Federal Government's withdrawal has been premature. In effect, the Federal Government now is aborting a program that was a good idea to begin with and, in its early years, showed a great deal of promise.

The Milwaukee experience illustrates what I mean.

During the first 2 years of the city's rat control program, total spending averaged about $600,000 each year, with the Federal Government putting up two-thirds and the city contributing one-third.

In 1971, the spending level increased to slightly above $800,000 and then gradually dropped back to below $600,000 in 1974. As the financial foundation was eroded, the program's early progress lost ground, too.

As one yardstick, consider the ratbite history. In the year before the control program was initiated, there were 12 reported ratbites in the target areas selected. This number was reduced steadily to a low point of two reported bites in both 1971 and 1973—years in which the program was in high gear. But as the financing was throttled down, the number of reported ratbites jumped to 13 in 1974; and through September of this year, another 13 have been reported already.

As another measurement, examine the "signs of rats" record. Prior to the Federal grant program, 39 percent of the target area showed "signs of rats." This was reduced to a low of 3.2 percent of the premises in 1973. This year, "signs of rats" have been reported in 10 percent of the premises.

Now, the Federal contribution to the Milwaukee rat control program is scheduled to end on December 31, 1976, and the city cannot afford to continue the campaign on its own. This would be a serious waste of the $2.8 million the Federal taxpayer already has invested in the city's efforts.

I believe this unfortunate prospect looms because of a misunderstanding of the Federal-city relationship in the fight to eradicate disease caused by rats. In truth, the "seed money" concept was never defined precisely and, because of that flaw, the whole program—nationwide, not just in Milwaukee—stands in jeopardy.

For this reason, I suggest these improvements in the grantmaking mechanism:

(1) The Federal Government should award grants to applicants on a 2-for-1 basis ($2 of Federal money for every $1 of local money) for as long as the local rat control program is in the "attack" phase and can show positive progress;

(2) The local community should be expected to take over the entire cost of the program only when the "attack" phase (meaning the "attack" on the conditions that breed the disease-carrying rats) is completed and the "maintenance" phase (meaning the "maintenance" of the sanitary conditions achieved) is begun;

(3) The current 8-year limitation on grants should be eliminated, in deference to the criteria cited above; or if some finite limit is deemed necessary, then perhaps 15 years might be preferable.

In my view, this would define an appropriate division of Federal-local responsibilities for rat control: The Federal Government's responsibility would be to provide a sufficient and continuous supply of funds to help communities rid themselves of the conditions that caused their rat problems; and the local communities' responsibility would be to take over the full cost of rat control only when that means maintaining sanitary conditions achieved with the help of Federal contributions.

In Milwaukee, if the funding mix were restored to the 1971 level—a Federal contribution of $544,000, a city contribution of $257,000, for a total program level of $811,000—it can be expected that the "maintenance" phase would be reached with a 3-year extension of the current grant.

In short, Milwaukee would solve its rat problem, with obvious benefit to the approximately 150,000 residents of the two target areas, by the end of 1979, instead of having the program collapse at the end of 1976.

Under criteria established by the Public Health Service, this would mean that no more than 2 percent of the premises in the target areas would have exterior rat signs; that no more than 15 percent of the premises would have exposed garbage; and that no more than 30 percent of the premises would have unapproved refuse storage.

These target areas are shabby. Such a cleanup would be a great accomplishment, both in human and financial terms.

In addition, sufficient and continuous funding of the program would have still another beneficial effect: It would provide jobs for the unemployed at a time when jobs are hard to find, especially for the unskilled. Milwaukee's program provided employment for 49 persons in 1970, but this work force now has been cut back to 24 persons.

The Comptroller General's report characterized the rat control program as "in trouble." With the changes I have suggested, it may be possible to salvage a worthwhile endeavor—not just for Milwaukee but for cities throughout the Nation that are attempting to cope with blight and disease.

Thank you, Mr. Chairman.

Mr. ROGERS. We are pleased to have very distinguished witnesses this morning, and the first witness is Gerald B. Greenwald, president-elect of the National Health Council, Inc., New York.

We welcome you to the committee, Mr. Greenwald, and will be pleased to receive your testimony, and you may proceed as you desire.

STATEMENT OF GERALD B. GREENWALD, PRESIDENT-ELECT, NATIONAL HEALTH COUNCIL, INC.

Mr. **Greenwald.** Mr. Chairman, members of the subcommittee, I very much appreciate this opportunity to address you this morning.

My name is Gerald Greenwald. I am appearing today in my capacity as president-elect of the National Health Council, Inc.

In May of this year, I testified before the Senate Subcommittee on Health, with regard to several proposals on health education similar to those before this committee. My statement fully describes the Council's interest in health education, as well as its other ongoing purposes.

In the interest of brevity, I will submit that statement as an addendum to my remarks today.

Mr. **Rogers.** Without objection, it will be made a part of the record. [See p. 320].

Mr. **Greenwald.** Thank you.

With this background in mind, I would like to provide the committee with some specific information which will serve as an introduction to witnesses who will be appearing before you as representatives of the National Center for Health Education.

In May, I reported to the Senate on the council's project to study the feasibility of a national center for health education. The project was generously supported by CDC's Bureau of Health Education, both with financial aid and by the advice provided by Dr. Spencer and by the co-project officers, Horace G. Ogden, Director of the Bureau, and Florence Fiori, Director of the Bureau of Health Resources Development, PHS Region II.

At the time of our testimony to the Senate last spring, this project had only just completed the development of the preliminary outline of its suggested center design. Today, I am happy to report to the distinguished members of this subcommittee that the council's project has now been successfully completed and that a National Center for Health Education—modeled after our project's recommendations—is in the process of raising funds, hiring staff, and developing specific program proposals.

I have provided copies of a pamphlet, "Toward Health Improvement," [see p. 351] to the subcommittee which very briefly summarizes our project's recommendations. In addition, I have also provided a copy of the introduction to the project's final report. The entire report is 576 pages in length and contains detailed summaries of each of the many meetings, conferences, and surveys from which the final recommendations were developed.

While this introduction was not intended to be a free-standing document, I think the subcommittee may be interested in its brief review of the elements that are included in the larger volume.

The council's project involved hundreds of individuals and organizations in the development of its findings. The process is outlined in Figure No. 2 of the introduction. The remainder of this document reviews the major recommendations concerning each of the project's contract requirements.

Briefly, some of the project's key findings are:

The National Center for Health Education should be a free-standing, nonprofit private organization.

The center should be a nonbureaucratic, national health education problem solving mechanism which would be dependent to a major degree on other organizations for input, resources, funding and the implementation of its policies and projects.

The center should concentrate its resources on the performance of leadership functions no other agency can deliver and avoid duplication of other public and private resources.

It is most desirable that the center be established and commence work without further delay. For this reason, the policy committee rejected the concept of creating the center by congressional charter.

The center should be funded by varying combinations of private and public funds including grants, contracts, and unrestricted donations. The center's support sources should be diversified and reflect balanced contributions by business and industry, private foundations, voluntary, and nonprofit institutions, and by the Federal Government.

Full-scale center operation will require approximately $1 million for the first year and should scale up to a continuing level of about $5 million annually. It is desirable for the center to develop a corpus from which these general operating costs can be met.

In addition to support for operating costs, the center should also seek variable additional amounts in grants and contracts from both private and public sources in order to accomplish a variety of special interests.

Stressing that the center should be created without further delay or loss of continuity with the project's efforts, the National Health Council's policy committee encouraged an already existing corporation, the Health Education Research Council, Inc., to take those actions required for it to become the National Center for Health Education. This has been done. Thus the center is now in the process of organizing for future activities.

The National Center for Health Education has the full endorsement and support of the National Health Council's Board of Directors. By unanimous vote on September 18, 1975, the Council's Board of Directors passed a resolution endorsing the center and urging its member agencies to support this new venture with funds and other forms of assistance. I have attached this resolution as part of my statement.

I would like to thank the subcommittee for this opportunity to appear before you. The council also would like to express its appreciation to those who, by introducing these proposals, have focused attention on the need to improve health education for the public. We believe that increasing the resources and assistance for this purpose is essential to our country's future well-being.

While there may be some disagreement about the most appropriate ways and means this can be accomplished, we believe there can be no doubt that it must be done.

Thank you.

[The attachments referred to follows:]

STATEMENT TO SENATE HEALTH SUBCOMMITTEE
May 8, 1975

BY: Gerald B. Greenwald,
President-Elect,
National Health Council, Inc.

"Need for a National Center for Health Education"

Mr. Chairman and Members of the Subcommittee:

My name is Gerald B. Greenwald. I am currently the President-Elect of the National Health Council, Inc. I have been a member of the Council's Board of Directors since 1969. I am also a practicing attorney and partner in the Washington firm of Arent, Fox, Kintner, Plotkin and Kahn, although it is not in this later capacity that I appear before this Subcomittee.

NATIONAL HEALTH COUNCIL -- WHAT IT IS AND WHAT IT DOES

The National Health Council is a private, non-profit membership organization that brings together over 70 of the nation's major voluntary health agencies, professional membership associations, government, business and insurance firms for the public interest of improving the nation's health through cooperative action. A list of the NHC member organizations is included as an attachment to the advance copy of my statement provided to the subcommittee.

The National Health Council was founded in 1920 by a group of health leaders who anticipated a vast expansion in health activities and foresaw the need for a meeting ground and coordinating mechanism for the growing number of national health agencies in the United States.

The National Health Council's goal is to improve the health of the public throughout the nation. Its principal functions are:

To help member agencies work together/more effectively in the public interest;

To identify and promote the solution of national health problems of concern to the public; and

To further improve voluntary and governmental health services for the public.

The Council's activities are guided by a 43 member Board of Directors. The governing board is representative of its member organizations together with significant participation from members of the public-at-large. The Council is incorporated under the laws of the State of New York and is classified as a 501 (c) (3) federally tax-exempt organization. Dues from member agencies constitute the major continuing source of Council income. Funds are provided for special projects by Federal grants and contracts and by support from foundations and the business community.

Millions of volunteers are associated with the Council's member organizations. They contribute time and talent in hospitals, rehabilitation centers, in recruitment of other volunteers, public and professional health education, charitable fund-raising, trustee service and a host of other activities for the benefit of the health of their fellow citizens. Member organizations also represent the highly trained core of people who provide health care to Americans as well as setting and maintaining professional standards for the health care this country receives. Although the NHC member organizations seek to accomplish a broad range of diverse purposes, they all have two things in common: First, they all share the common mission of improving the nation's health; and second, they are concerned with the ways and means the nation's health can be improved by educational methods.

The Council's member agencies have a most distinguished history in the field of health education. Until well into this century the only national health education efforts were conducted by our member agencies. Today, the programs of our voluntary health agencies and health professional associations overwhelmingly represent the major portion of national effort in this field. The national organizations which are our members spend more than 35 million dollars annually on direct public health education. This is only a small protion of the total amounts devoted to public health education by their state and local affiliates and chapters. While the efforts of our members have accomplished much to alert the public to the actions they can take to protect and maintain their own health, the need for rapid and dramatic improvement in our national approach to health education of the public is urgent.

This need cannot be served by informational campaigns and the traditional educational approaches alone. A more sophisticated approach, involving every sector of our society, must be developed and implemented in order to impact on the nation's health through educational means. To achieve this purpose:

1. The public must be informed about health as well as disease, and about the ways they can best protect and improve their health;

2. The public must develop the ability to examine health options, weigh consequences and make their own decisions concerning the health practices most appropriate for them, their families, and their communities;

3. The public must be motivated to desire changes supportive of more healthful life-styles and living practices; and

4. The impediments that inhibit the voluntary adoption and maintenance of more healthful practices by the public must be identified and mitigated or removed.

NEED FOR NATIONAL ACTION IN HEALTH EDUCATION AND PROMOTION

From its inception, this nation has recognized and supported the principle that an educated public, freely exercizing personal, private choices in our society, is the foundation of democracy. Despite the general acceptance of this principle, we have never had a national strategy and, for the most part, have also lacked state and local strategies to assure that our people are equipped to make the crucial choices about their own and their community's health.

The reasons for this deficiency are varied and complex. To put it in the simplest fashion, however, until comparatively recently we have not had the knowledge, the sophisticated technologies, nor the resources with which to enable everyone in this country to make choices between actions which protect and maintain their own and their community's health, and those actions which are directly or potentially hazardous to their own and other people's health.

While we are certainly not yet at the point where health and long life can be guaranteed to every citizen by medical science, we are at the point where a rather large portion of the diseases, illnesses, injuries and untimely deaths which occur could have been prevented. We are at the point where the effects of those diseases, illnesses and injuries which can not be prevented could be greatly reduced by the informed and cooperative participation of patients in their treatment.

Without taking the Subcommittee's time to review evidence which is already familiar to you, it is obvious from the statistics available concerning accidental deaths and injuries, suicide, alcoholism, smoking and other forms of drug abuse, obesity, those forms of chronic disease in which life-style and/or occupation is a major contributing factor, and from epidemics of communicable disease in which failure to secure available innoculations or preventive care is a causal factor, that the majority of our population is not taking those actions which protect and maintain health to the maximum extent possible. All of this adds up to a nation which is a lot less healthy than it could and should be.

Over the past decade we have seen an enormous growth of awareness in every sector of our society concerning citizens' responsibilities for their own and their community's health. We have also seen that there are no easy answers to the preservation of a quality environment, to distribution of nutritious foods, to the equitable and accessible distribution of quality medical care, and to the maintenance of an expanding, full employment economy. These difficult and complex issues are being explored with growing sophistication by health professionals and specialists, by politicians and community leaders, by the media, and, most important of all, by the public whose day-to-day decisions are the most critical determinant of the nation's health.

In this search for solutions to the complex and pressing problems of our society's long-term survival, general awareness is growing that health education of the public is the vital and too often missing key to appropriate and acceptable strategies of solution. This need for more effective public health education has long been recognized and advocated by the National Health Council and its member organizations.

This need is now more generally recognized by labor unions, by leaders in business and industry, and throughout government. The number of organizations and groups which are seeking guidance and information for the development of both general and special purpose health education programs is large and growing. The number of organizations which could productively use financial assistance for well planned health education programs is also increasing. We are convinced that the opportunity now exists to dramtically expand the effectiveness and efficiency of our public health education efforts nationwide.

What is needed is some way for the many separate organizations which are currently conducting programs of health education to make their efforts more productive through pooling of ideas, agreement on common strategies and cooperation in securing for health education a more adequate share of the nation's resources. The cost-benefit of such an effort would be enormous.

NATIONAL HEALTH COUNCIL'S PROJECT TO DESIGN A NATIONAL CENTER FOR HEALTH EDUCATION

I am confident that the members of this Subcommittee are aware of the work and final Report of the President's Committee on Health Education. The National Health Council assisted in this effort in a variety of ways. The Council provided financial management services to the Committee; it loaned staff for work on a number of specialized areas under review by the Committee; and it sponsored an open review of the Committee's interim findings at its 1971 National Health Forum.

Based on a survey of health education efforts in both the public and private sectors, the President's Committee recommended the creation of a federal focal point for health education as a unit within the governmental structure and the creation of a private organization to be known as a National Center for Health Education.

The Report of the President's Committee on Health Education was presented to the President in September, 1973. After study by a task force of the Department of Health, Education and Welfare, two actions pursuant to the Committee's recommendations were taken: First, a Bureau of Health Education was created as a unit of the U.S. Center for Disease Control of the Department of Health, Education and Welfare; and, second, the National Health Council, Inc. was awarded a contract to perform a one-year feasibility study concerning the design of a private National Center for Health Education. This project is nearing completion of its work.

Throughout this project we have worked very closely with the Bureau of Health Education and have found that this cooperative association has been most productive. It is obvious that there is a need for a complimentary relationship beween the federal efforts to develop an official strategy for health education in the public sector and private efforts to perform closely allied functions within the private sector.

Because there is a very close similarity between the statement of mission and functions which are described for the 'Institution for Health Education and Promotion in Part B of S.1467 and those that have been developed for a National Center for Health Education by the National Health Council's project, I am providing the Subcommittee with copies of the NHC's Preliminary Report on the Development of a Plan to Establish A National Center for Health Education and other related documents as a part of my statement. This Report was submitted to the U.S. Center for Disease Control (Reference Number CDC 21-74-522) as of March 1, 1975.

The Council's project has been directed by a distinguished twenty-three member policy committee appointed by the Board of the National Health Council. Heading this panel is Arthur C. Nielsen, Jr., President of A.C. Nielsen Company, Chicago. Mr. Nielsen was also a member of the President's Committee on Health Education. Vice-chairman is Jennette J. Simmons, D.Sc., Associate Professor at the Harvard School of Public Health. Committee members include: Paul S. Archambault, Director of the Division of Materials Development, American Heart Association;

Henry [illegible], Vice President for Public Relations and Advertising, Prudential Insurance Company; Howard J. Berman, Vice President, Health Care Services, Blue Cross Association; E. Leon Cooper, M.D., practicing physician; Marguerite de la Vega, Acting Director of Health Education, The Permanente Medical Group; Carol N. D'Onofrio, Dr.P.H., Assistant Professor of Public Health, University of California at Berkeley; Herbert K. Gatzke, Director of the Bureau of Manpower and Education, American Hospital Association; Evalyn Gendel, M.D., Director of the Bureau of Maternal and Child Health, Kansas State Department of Health; Lawrence W. Green, Dr.P.H., Head of the Division of Health Education, Johns Hopkins School of Hygiene and Public Health; Marian V. Hamburg, Ed.D., Director of Health Education at New York University; Eunice Hankins, Director of Program Planning and Community Development, Department of Health Services, San Gabriel Valley Region; Gerald Kurtz, Manager of Corporate Communications, Eli Lilly and Company; Seymour Lieberman, Ph.D., President of Lieberman Research Inc.; Roy L. Lindahl, D.D.S., Director of the Office of Continuing Education, University of North Carolina School of Dentistry; A. Helen Martikainen, Dr.Sc., former Chief of Health Education, World Health Organization; Eva M. Reese, Executive Director of the Visiting Nurse Society of New York; Sheldon W. Samuels, Director of Health, Safety and Environment, A.F.L.-C.I.O.; Harry Schwartz, Visiting Professor of Medical Economics, College of Physicians and Surgeons, Columbia University; Earl Ubell, Ph.D., Director of Television News, WNBC-TV; D. Douglas Waterstreet, Associate Director of the National Association for Mental Health, Inc.; and Wallace Ann Wesley, Hs.D., Director of Health Education, American Medical Association.

The preliminary Report which I have submitted to this Subcommittee has been unanimously supported by this Policy Committee. The Council's interest in performing this feasibility study has been to support and encourage the development of improved private initiatives in health education of the public. To this end, the National Health Council has attempted to involve as many organizations and interested individuals as possible in this project. While somewhat lengthy, I think the Subcommittee may be interested in reviewing the many varied sources of input and the processes by which the mission and functions described for a National Center for Health Education were developed by the Council's project.

NATIONAL HEALTH COUNCIL'S POSITION ON A NATIONAL CENTER FOR HEALTH EDUCATION

At its most recent Board meeting on March 18, 1975, the Board of the National Health Council endorsed the mission and functions recommended by the Policy Committee in its Preliminary Report. The Council feels that the establishment of such a Center in the private sector would be of enormous value in strengthening private sector health education efforts. At this point in the project the Council's Board is still reviewing the organizational arrangements which would be most appropriate for such a Center. The Board has affirmed, however, that the Center should be an independent, free-standing private organization.

COMMENTS ON LEGISLATIVE PROPOSALS BEFORE THIS SUBCOMMITTEE

The Council would like to express its appreciation to those who, by introducing these proposals, have focused intensified national attention on the vital question of how we, as a nation, can improve the health education of the public. Increasing the assistance and resources available for this purpose -- a common feature of each of the proposals before you -- is surely essential and long overdue.

While there may be disagreement on the specifics of the organizational structures required to accomplish the tasks at hand, I hope that there is no disagreement that now is the time for action. I also would hope that the contributions of the many organizations in the private sector, especially those of the member agencies of the National Health Council, to public health education over the past decades will be recognized, and, consequently, that a complimentary strategy of joint public-private intitiatives will be the foundation for efforts to improve health education nationwide.

In conclusion, there is one point on which I would like to comment with regard to the proposals before you. As a result of the work of the President's Committee and of our project, the name 'National Center for Health Education' has achieved a certain degree of visability and good will in the past three years. It is a term which is particularly associated with the private sector's efforts to create a national organization with substantial financial support from private sources. We would hope, therefore, that this Subcommittee might consider the overall advantages of not utilizing this name or closely similar variations in describing proposals to create any federal governmental unit. We feel that the resulting identity confusion would be seriously detrimental to efforts to raise private support for a National Center for Health Education.

I thank the Subcommittee for this opportunity to provide information on the proposals before you.

Preliminary Report —— Policy Committee National Center for Health Education

INTRODUCTION

For each category of contract information and materials this section of the final report reviews:

1) Contract Requirements;

2) Process of Accomplishment: and

3) Major Findings.

This project was faced with a number of challenges, not all of which could be resolved within the limits of the project's responsibility. While it was clear that the contract charge was to perform a feasibility study, it was equally understood that the only fully satisfactory end-result of this effort to all concerned had to be either the creation of a National Center for Health Education with major private sector financial support or else a finding that such an organization was not practical.

Another challenge centered on the fact that many of the required design elements suggested a wide range of alternative options all of which might have been considered appropriate in the abstract. At the same time, several potentially desirable options did not appear to be legally, economically, or politically feasible at the outset.

Still another area of difficulty centered on the project's ties to the work of the President's Committee. Their Report had left major issues unresolved and given rise to dissenting opinions among the Committee members as well as other interested groups. These issues and some residual suspicions concerning the project's anticipated outcomes had to be resolved if the project's findings were to be acceptable to the Center's potential future constituencies.

All of these factors indicated that a relatively high degree of outside participation and creative problem-solving would be required to achieve the project's objectives. It also dictated the need for flexibility in adapting the plan of work along the lines of development suggested by the participants.

The accompanying Figure 1 displays the plan of work originally prepared for the project. Figure 2 shows the work sequence which actually occurred.

As shown in these figures, some of the originally projected tasks were combined or modified in various ways to meet the actual needs for additional input which emerged in the later stages of work.

Undoubtedly the major factors which necessitated amendments in the plan of work were:

1) Early emergence of an organizational concept for the Center which fundamentally differed from that suggested by the President's Commiteee on Health Education;

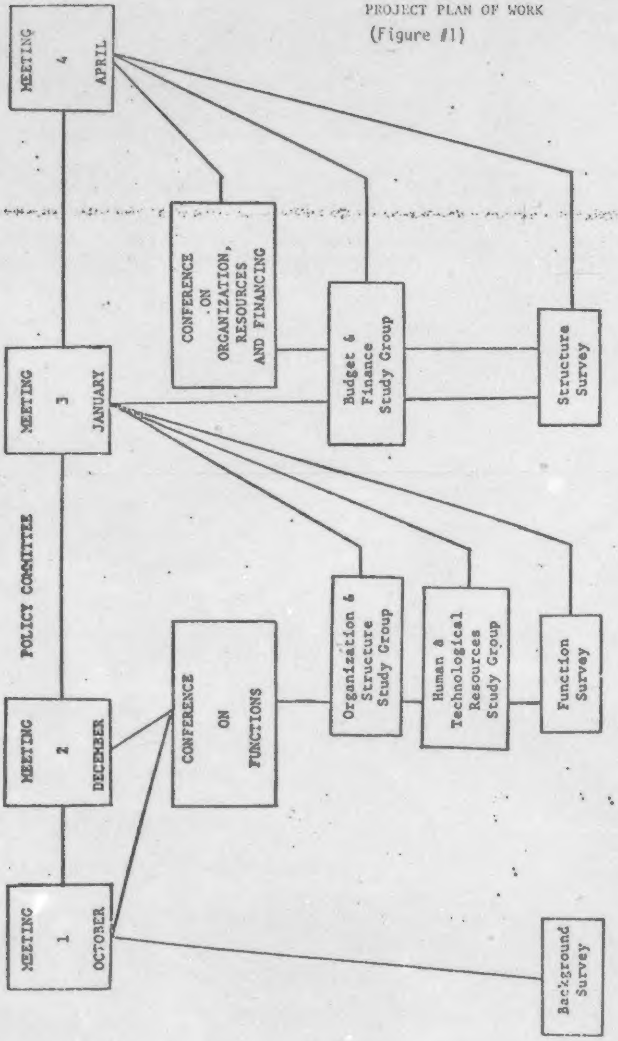
2) Strong consensus among a large portion of the project participants that the Center should be established as soon as possible and their consequent frustration with 'studying' ways and means in the abstract prior to taking action.

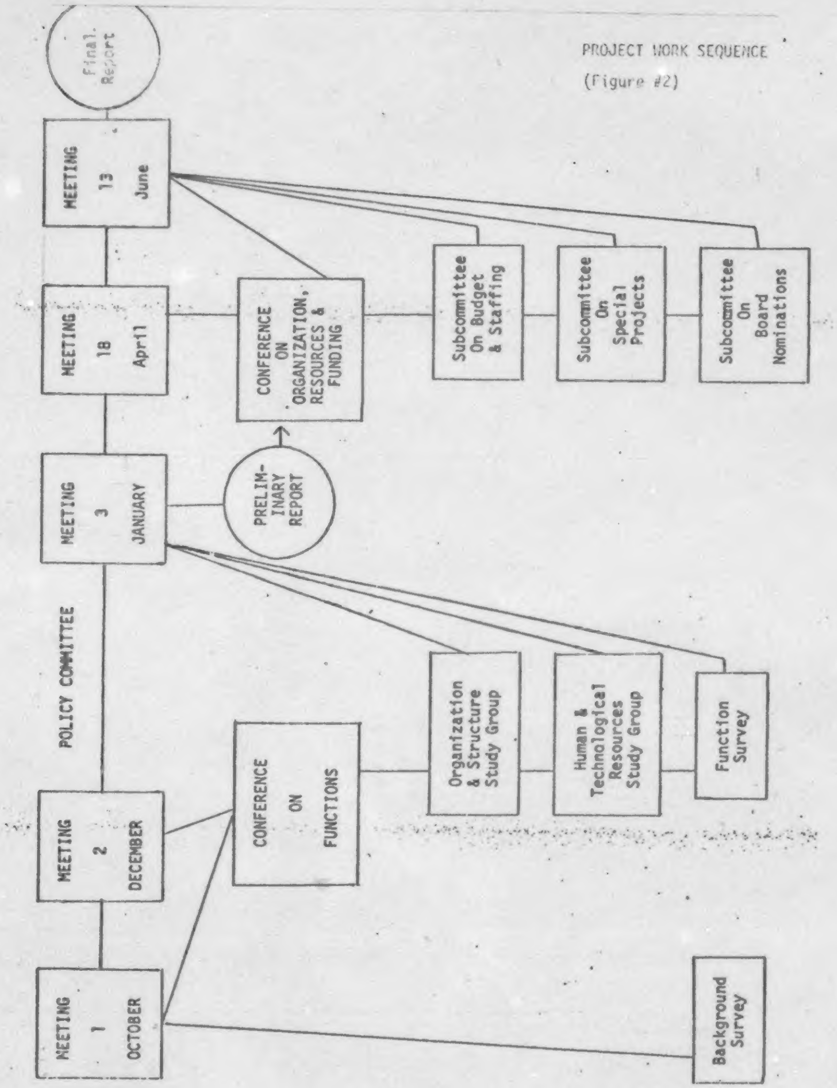
Despite the adaptations these factors dictated, the basic task objectives, assumptions, and group process decision-making approach described in the original technical proposal did not vary.

The product of this project is a concept of and action plan to establish a National Center for Health Education. It is a proposal to which many individuals have significantly contributed and about which they feel varying kinds of commitment. Actions to implement the findings of this study are already being taken by a number of cooperating organizations, especially by the Health Education Research Council, Inc. which is in the process of changing its name to 'National Center for Health Education' and expanding its activities to implement the Center design recommended by this project.

As work on support agreements and Center organizing tasks proceeds, it can be anticipated that several of the suggestions developed in the course of this project will be modified by experience. It also is expected that, like the evolution which occurred in this project's plan of work, such changes will enhance rather than change the basic thrust of the Center's design.

PROJECT PLAN OF WORK
(Figure #1)


POLICY COMMITTEE
MEETING 1 OCTOBER
MEETING 2 DECEMBER
MEETING 3 JANUARY
MEETING 4 APRIL
CONFERENCE ON FUNCTIONS
CONFERENCE ON ORGANIZATION, RESOURCES AND FINANCING
Organization & Structure Study Group
Human & Technological Resources Study Group
Budget & Finance Study Group
Background Survey
Function Survey
Structure Survey



PROJECT WORK SEQUENCE

(Figure #2)

POLICY COMMITTEE
MEETING 1 OCTOBER
MEETING 2 DECEMBER
MEETING 3 JANUARY
MEETING 18 April
MEETING 13 June
Final Report
Background Survey
CONFERENCE ON FUNCTIONS
Organization & Structure Study Group
Human & Technological Resources Study Group
Function Survey
PRELIMINARY REPORT
CONFERENCE ON ORGANIZATION, RESOURCES & FUNDING
Subcommittee On Budget & Staffing
Subcommittee On Special Projects
Subcommittee On Board Nominations

I. OBJECTIVES AND FUNCTIONS

A. Contract Requirements:

1. The Contractor will develop appropriate long-range and short-term objectives for a National Center for Health Education.

2. The Contractor will ascertain what specific functions a National Center for Health Education should perform and establish their relative priorities, a phased schedule for initiation of activity, i.e., which should be undertaken in the initial year of operations, second year of operation, etc.

B. Process of Accomplishment:

The major portion of project effort was devoted to the development of findings on these issues. The statement of mission, objectives and functions described for a National Center for Health Education in the summary of this project's findings and recommendations reflects an evolutionary process of suggestion, debate and refinement. In addition to the deliberations of the Policy Committee, the major inputs to this portion of project work included:

1. Work of the President's Committee on Health Education as documented in:
    a) Report;
    b) Committee Files
    c) Interpretations and additional information provided by interviews with former Committee members and staff.

2. Results of survey and update of testimony given at Regional Hearings sponsored by the President's Committee;

3. Suggestions of representatives of the National Health Council's member agencies;

4. Findings of Functions Conference;

5. Results of Functions Mail Survey.

During the first quarter of project work, all of the materials compiled or developed by the President's Committee on Health Education were analysed and a brief review of the Committee's process, major recommendations of its subcommittees and major position papers was prepared. (Tabs I-1, I-2, & I-3) A letter was sent to each individual who had testified at the eight regional hearings asking for an update on their testimony plus any comments they cared to volunteer concerning the project's tasks. (Tab I-5) In addition, representatives from all of the National Health Council's member agencies were invited to a briefing and asked for their suggestions concerning appropriate Center objectives and functions. (Tab I-4)

The President's Committee Report and Supplemental Information, summaries of the N.H.C. agency representatives' meeting and first mail survey were mailed to the Policy Committee together with an idea outline for their discussion of Center goals, objectives and functions. (Tab I-6)

At its first meeting, the Policy Committee generally agreed upon eight functional areas which they considered to have the highest priority for further exploration. (Tab I-7)

Based on the Policy Committee's suggestions, a brief statement of definition, needs, goals and objectives, benefits. possible activities and constraints for the eight functional areas was prepared. (Tabs I-8 &I-9) This statement was reviewed and modified by 72 participants at a conference held outside of Chicago, December 4 and 5, 1974. Participants included representatives of health care, professional, consumer, labor, education, business and other concerned groups as well as educators and practitioners specifically in the field of health education.

After an introductory general session, the participants were divided into eight discussion groups, each of which developed recommendations for a separate functional area. Analysis of these group reports resulted in some modifications of content and changes in emphasis in the description of Center mission, goals and functions. (Tab I-10)

Following this conference, a two page questionnaire briefly describing the proposed functions was mailed to 700 organizations and individuals. The 351 responses to this questionnaire significantly supported the concept of a National Center and the importance of the proposed functions. (Tab I-11)

At its third meeting, the Policy Committee reviewed the Functions Conference and mail survey findings and developed further amendments to the statement of Center goals, objectives and functions to be presented in the project's Preliminary Report. (Tabs I-12 & II-3)

The Center objectives and functions recommended by the Policy Committee were endorsed by the National Health Council's Board of Directors at their March 18. 1975 meeting. Since then the Preliminary Report has been widely circulated to interested organizations and individuals for their review and comments. Informal reactions to the Center proposal have been uniformly favorable.

The statement of goals and functions also was reviewed in detail by the forty-nine participants at a Conference on Organization and Funding held in Alexandria, Virginia in mid-April. It was their general opinion that the concept of a National Center as described in the Preliminary Report was both needed and supportable, and that such an organization would be of tremendous value to a wide variety of organizations and groups. The participants urged that actions to create the Center should be undertaken as soon as possible. (Tab II-7)

Finally, some further editing and refinement of the statment of objectives and functions was agreed upon by the Policy Committee at their fourth and fifth meetings. (Tabs II-8 & II-9)

C. Major Findings:

The Policy Committee unanimously agreed that:

1) the need for and importance of a National Center for Health Education had been demonstrated by the work of the President's Committee on Health Education and by this project;

2) The Center should be a non-bureaucratic, national health education problem-solving mechanism which would be dependent to a major degree on other orgranizations for input, resources, funding and the implementation of its policies and projects;

3) The Center should concentrate its resources on the performance of leadership functions no other agency can deliver and avoid duplication of other public and private resources; and

4) Specific program objectives and priorities should be established by the Center's Board of Directors based on input from supporting and endorsing organizations.

Several factors contributed to the Policy Committee's development of its concept of the Center as a non-bureaucratic, problem-solving mechanism:

1) scope and magnitude of nationwide consumer health education needs and problems;

2) pervasive deficiencies in existing health education methodologies and general absence of agreed upon evaluation methods;

3) scarcity of health education resources and funding support; inefficient utilization of the resources and funds that do exist;

4) fragmentation of health education programs among a multiplicity of providers operating in isolation from one another; and

5) general lack of continuity or integration of content among differing consumer health education efforts.

In the Committee's opinion all of these factors underscored the need for a Center which would concentrate its resources on 'leadership' functions which no other agency could perform. They unanimously agreed that the Center should avoid the performance of those kinds of routine service functions which would be a drain on its limited resources and which could significantly reduce its freedom to initiate and explore innovative policy and program options or to influence service development by outside organizations.

The Policy Committee selected seven major leadership functions the Center should perform: Consensus Building; Policy Determination; National Strategy Design; Health Education Advocacy; Data Base Development and Information Exchange; Technical Assistance; and Evaluation, Testing and Demonstration. Each of these functions was seen as having equal priority and mutual interdependency.

The Policy Committee unanimously agreed that the Center's legitimacy in performing these functions and indeed its essential character as a private sector problem-solving mechanism would lie in it dependence on external organizations, individuals, and groups for input, resources, funding and the implementation of its policies and projects. They saw the Center as an open process of decision-making and action which would involve functioning through a wide variety of outside agencies, groups, sources of expertise, and opinion leaders at the points most relevant to their interests and potential contributions to the Center's work.

Although the Policy Committee rejected the idea of the Center as a membership organization, they agreed that it should be linked to a comparatively large number of outside organizations by a variety of formal and informal mechanisms.

Because of this emphasis on external participation, the Policy Committee agreed that it would not be desirable for this project to attempt to rank order or assign priorities among the wide range of specific substantive objectives and activities which had been suggested for the Center. It was the Committee's unanimous opinion that such determinations should be the responsibility of the Center's Board of Directors and that supporters and cooperating organizations should be involved in this process as an essential part of the Center's consensus building activities during its organizing stage of development.

The Policy Committee saw the immediate objectives and sequence of activities between the conclusion of project work and the full range initiation of the functions proposed for the Center occurring in two stages.

A period of interim development lasting about 6 to 9 months will be required to organize the Center as a free-standing entity. During this period short-term objectives would include completion of legal requirements for the Center's establishment as a tax-exempt, non-profit corporation; obtaining funding for the interim period and development of a detailed fund-raising campaign; appointment of the Board of Directors, Advisory Panel, and President; hiring an initial core staff and identification and development of agreements with primary supporting and endorsing organizations.

The second stage would focus on four primary objectives: completion of fund-raising to support the Center's first five years of operations; development of continuing linkages with a large, representative sample of the Center's potential users and supporters; development of the Center's detailed work program based on suggestions and agreements of cooperating organizations; and initiation of some representative policy and special project activities. It is anticipated that it will take approximately two years to accomplish these organizing and program development objectives.

II. ADMINISTRATIVE AND MANAGEMENT STRUCTURE

A. Contract Requirements:

1. The Contractor will develop an appropriate administrative structure for such a Center ascertaining the advantages and disadvantages of a legislative charter as a quasi public institution or a private non-profit corporation. If a legislative charter is deemed advantageous, determine the best way to develop requisite legislation.

2. The Contractor will develop a model for the board of directors of the Center including appropriate representation, how they are to be selected and appointed; and ascertain the appropriate role of the Board in establishing policies and operating procedures for the Center.

3. The Contractor will develop a proposed staffing pattern required to perform desired functions in the first year, including disciplines or areas of expertise that should be represented on staff and salary level ranges for the director and his professional staff.

B. Process of Accomplishment:

Major inputs to the findings for this portion of project work included:

1. Findings of a Study Group on Organization, Structure and Relationships;

2. Findings of a Study Group on Human and Technological Resources;

3. Recommendations of T. Schmidt and Associates on Organizational Form;

4. Findings of a Conference on Organization and Funding;

5. Recommendations of a Subcommittee on Board Nominations; and

6. Recommendations of a Subcommittee on Staffing and Budget.

Following the development of a statement of mission, objectives and functions as suggested by the Policy Committee and Functions Conference participants, two small Study Groups were appointed to make recommendations concerning alternative options for the Center's Organization, Structure, and Relationships and its Human and Technological Resource needs. (Tabs II-1 & II-2)

The reports of these groups were reviewed by the Policy Committee at its third meeting. (Tab II-3) The general outline of the organizational structure approved at this meeting was then prepared for presentation in the project's Preliminary Report. (Tab II-4)

An outside consultant was employed to review the preliminary findings on organizational form and make recommendations to the Policy Committee. (Tab II-5) These recommendations together with the findings of a Conference on Organization and Funding at which 49 generally representative opinion leaders reviewed the Preliminary Report (Tabs II-6 and II-7) were acted upon by the Policy Committee at its fourth meeting.

At this meeting, the Policy Committee endorsed the offer of the Health Education Research Council, Inc. to take action to become the National Center for Health Education. A Subcommittee on Nominations to the Board of Directors was created as was a Subcommittee on Budget and Staffing. (Tab II- 8)

The reports of both of these Subcommittees were received and acted upon at the fifth and final Policy Committee Meeting. (Tabs II-9, II-10, & II-12)

C. Major Findings:

The Policy Committee unanimously agreed that:

1. The National Center for Health Education should be a free-standing, non-profit private organization.

2. The Health Education Research Council, Inc. should be encouraged and supported to take those actions required for it to become the National Center for Health Education and implement the proposal developed by this project.

3. It is most desirable that the Center be established and commence work without further delay. For this reason the Policy Committee rejected the concept of creating the Center by Congressional charter.

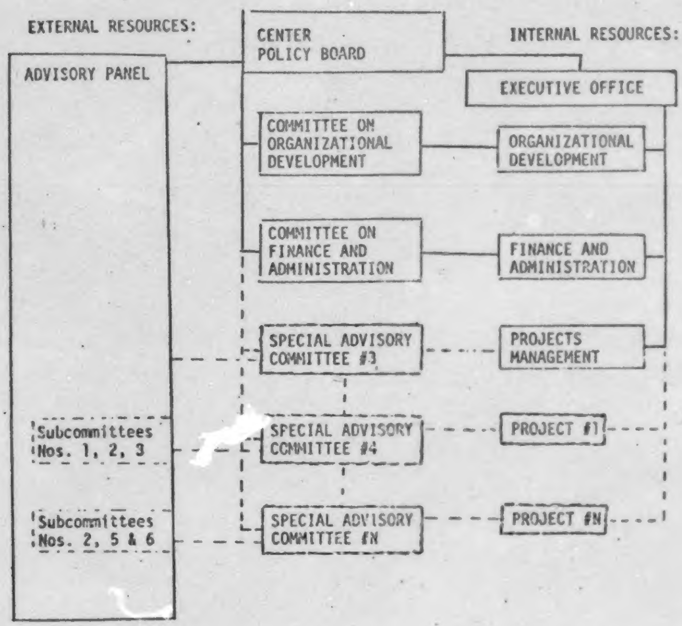
4. The Center should be directed by a twenty-five member Board of Directors. Members of the Board should serve as individuals and not as the official representatives of outside organizations. An independent nominating committee should be formed to review and select candidates for election to the Board. The Board's principal functions will include Center program direction; all financial policy determinations; representation of the Center to outside organizations; creation and appointment of committees, task forces and study groups; and appointment of the Center's President.

5. The Center's staff should be headed by a President to be named by the Board. Staff organization should be modeled on a matrix (rather than a bureaucratic) organizational design which stresses the accomplishment of tasks by ad hoc teams and special project activity in combination with routine program functions. The initial core staff should be small in number and emphasize coordinative, program design and management, group process, and communication skills. Members of the Board and Advisory Panel, staff on loan from cooperating organizations and outside consultants should be utilized in addition to Center staff to complete special project activities..

6. In addition to the Board of Directors, there should be a large panel of about two hundred individuals representing the same kinds of competencies and abilities as those described for Board membership. This panel would provide advice to the Board on policy matters and would be the primary source for appointments to special committees and study groups.

The Policy Committee found that the matrix concept had significant advantages for the Center's functions over more traditional bureaucratic structures.

RECOMMENDED CENTER COMPONENTS:


EXTERNAL RESOURCES:
ADVISORY PANEL
Subcommittees Nos. 1, 2, 3
Subcommittees Nos. 2, 5 & 6
CENTER POLICY BOARD
COMMITTEE ON ORGANIZATIONAL DEVELOPMENT
COMMITTEE ON FINANCE AND ADMINISTRATION
SPECIAL ADVISORY COMMITTEE #3
SPECIAL ADVISORY COMMITTEE #4
SPECIAL ADVISORY COMMITTEE #N
INTERNAL RESOURCES:
EXECUTIVE OFFICE
ORGANIZATIONAL DEVELOPMENT
FINANCE AND ADMINISTRATION
PROJECTS MANAGEMENT
PROJECT #1
PROJECT #N

The Policy Committee agreed that selection of a matrix structure for the Center is consistent with the findings of management research concerning the advantages of open systems for creative problem-solving situations. The matrix concept has been successfully employed in business and industry and by the government especially for research and development functions. Among its advantages are efficiency in utilizing limited resources to accomplish diverse objectives, effectiveness in merging multidisciplinary input in differing patterns as required to accomplish varied tasks, and flexibility of response to changes in organizational priorities and external needs.

The Committee considered that such an approach would be compatible with either a private or a Congressionally chartered institution. Their review of the advantages and disadvantages of these alternatives accordingly focused on other issues.

The Committee generally agreed that a Congressional charter which would establish the Center as a quasi-public institution offered the following advantages:

1) Some greater degree of legitimacy and stability than a private organization would enjoy;

2) More formal communication and involvement of interests and expertise from both public and private sectors in policy development and program planning; and

3) Greater probability of combined utilization of public and private resources in the development and implementation of concerted national strategies to improve health education nationwide.

They saw the disadvantages of such a charter as:

1) greater restrictions on the Center's ability to advocate the adoption of its policies especially when legislative action is required;

2) significant hindrance of the Center's flexibility in its relationships with private sector organizations, and

3) length of time and uncertainty of the process required to obtain a charter.

The fact that Congress has not acted favorably on any request to charter a private organization since 1964 weighed heavily in the Committee's rejection of this method of establishing the Center. The Committee suggested that the Center should be created without any further delay and that, once created, the Center could seek a charter if it appeared desirable. In any case, the Policy Committee considered the creation of the Center by private action preferable even if a charter was obtained at some later date.

The Committee found that creating the Center as a free-standing non-profit corporation also represented some difficulties and possible delays. If the corporation were to be initiated as a entirely new venture, it would probably take a minimum of 18 months and could take as long as three years for it to achieve federally tax-exempt status. Fund-raising in the interim would necessarily be very adversely affected.

Accordingly, the Committee identified two organizations which had been created to pursue purposes in support of health education very closely similar to the mission described for the National Center. Both of these organizations were federally tax-exempt 501 (c) (3) corporations located in New York State; neither had on-going program commitments which would conflict with changing the organization's name and expanding activities towards implementation of the project's proposal. Both organizations expressed willingness to undertake such changes either individually or by a merger. For technical reasons having to do with the articles of incorporation, only one of these organizations, the Health Education Research Council, Inc. was able to make the necessary changes.

It was, therefore, the unanimous finding of the Policy Committee that the Health Education Research Council, Inc. should be encouraged and supported in its actions to become the National Center for Health Education. The Committee agreed that, of all the alternative possibilities they had reviewed, this method of establishing the National Center was the most practical, appropriate and acceptable.

A Subcommittee of both the Health Education Research Council and the Policy Committee was appointed to develop nominations for election to the Center Board. (See Tab II-10 for list.) Those nominated by this process were elected to office by formal action of the H.E.R.C. Board at its annual meeting on June 20, 1975. It will be the responsibility of this Board to elect the Center's officers, recruit and appoint its President, raise funds, determine program priorities, appoint the Advisory Panel and such other committees it finds appropriate.

A suggested core staffing pattern and salary ranges was developed by a Subcommittee of the Policy Committee (See Tab II-9, pp. 4-6). Reviewed and endorsed by the full Policy Committee at its fifth and final meeting, this report suggests an inital core staff of 18 to be acquired over a year's time. Principal positions include a President and three Directors for 1) Organizational Development, 2) Financial Management and Administration, and 3) Project Management.

III. FUNDING SOURCES AND LEVEL:

A. Contract Requirements:

1. Assuming $500,000 Federal contribution is available the first year of operation, the Contractor will determine appropriate potential sources of private sector support and determine appropriate level of private funding to be sought for the first year and subsequent years and the appropriate mix of private-Federal funding.

2. The Contractor will determine an appropriate procedure to approach potential supporters to solicit funds taking into consideration the need to assure continuity of support from the private sector and determine whether contributors should be able to influence ways in which their contribution is spent.

B. Process of Accomplishment:

Major inputs to the findings for this portion of project work included:

1. Findings of a Study Group on Organization, Structure and Relationships;

2. Findings of a Conference on Organization and Funding;

3. Recommendations of Subcommittee on Staffing and Budget; and

4. Recomendations of Subcommittee on Specific Projects.

At its first meeting the Policy Committee agreed to assume for purposes of discussion that the Center would start off with a budget of about $1 million annually, at least one-half of which would be provided by private sources. (Tab I-7)

Having developed the essential outline of the Center's mission, functions and organizational structure as outlined in the project's Preliminary Report (Tabs I-12 & II-4), 49 participants including health educators, representatives of business, industry and labor and from health, education and civic organizations were invited to a conference held in Alexandria April 17 and 18. Participants were asked for their suggestions concerning sources of funding and types of approach which should be used to offer the Center concept to potential supporters. (Tab II-6)

Working both in small groups and in general sessions, the participants generally agreed that such a Center could attract private sector support. They also agreed, however, that it would be impossible to make specific suggestions concerning types of approach and sources without more specific information concerning the sponsorship and methods by which the Center would be created. Participants generally endorsed the suggestion that some agency should take the initiative to establish the Center and develop specific budget proposals to which funding sources could react. (Tab II-7)

At its fourth meeting immediately followed this conference, the Policy Committee took action to endorse the offer of the Health Education Research Council, Inc. to become the National Center for Health Education. It also appointed a Subcommittee on Staffing and Budget to develop a suggested budget proposal. (Tab II-8)

The recommendations of this Subcommittee (Tab II-9) were approved by the Policy Committee at its fifth meeting. At this meeting the Policy Committee also reviewed suggestions for funding approaches including suggestions for specific project proposals developed by a Subcommittee. (Tab II-11)

At its final meeting the Committee developed some general advisory suggestions for the new Center's fund-raising strategy and concluded that it would not be appropriate for them to attempt to secure support commitments on behalf of the Center. (Tab II-12)

C. Major Findings:

The Policy Committee unanimously agreed that:

1. The Center should be funded by varying combinations of private and public funds, including grants, contracts and unrestricted donations.
2. Full scale Center operation will require approximately $1 million for the first year and should scale up to a continuing level of about $5 million annually. It is desirable for the Center to develop a corpus from which these general operating costs can be met. Given the poor economic climate it is expected that such a corpus will take several years to develop.
3. In addition to support for core operating costs, the Center should also seek variable additional amounts in grants and contracts from both private and public sources in order to accomplish a variety of special projects. Thus, the total annual income required to achieve the Center's program objectives in any given year should vary substantially depending on changes in program priorities and on the extent to which external organizations voluntarily undertake the performance of Center designed projects without using the Center as a fiscal agent.
4. The Center should be established and developed regardless of the level of funds raised. If it proves impossible to raise the total amounts required for full scale operation, then the Center should begin operation at a lower level and begin to demonstrate its potential worth to supporters.
5. The Center's support sources should be diversified and reflect balanced contributions by business and industry, private foundations, voluntary and non-profit institutions and government.
6. In-kind contributions of time and effort, equipment, etc. should be encouraged, especially from health and educational institutions and from business and industry.

The development of a fund-raising strategy for the Center was clearly the most difficult challenge of the entire project. Having determined that the Center should be a free-standing organization, the Policy Committee was left with a dilemma concerning its own role and responsibility for the Center's fund-raising.

The Policy Committee, based on the recommendations of the participants at the Conference on Organization and Funding, agreed that an agency had to be designated which could make fund-raise for the Center with potential sources of support. Without clear understanding on this point it would be impossible to go beyond generality and actually obtain commitments for support.

Having endorsed action by the Health Education Research Council, Inc. to become the National Center for Health Education, the Policy Committee unanimously agreed that it would not be appropriate for them to solicit funds on behalf of the Center until the Center's Board had met and developed its own guidelines for fund-raising.

The Policy Committee suggested that the Center's Board should appoint a fund-raising committee; that it should develop a packaged presentation which could be used by fund-raisers; that a portfolio of possible special projects should be prepared to indicate the kinds of activities the Center would undertake with ear-marked funds; and that in-kind contributions should be included in the support raised, especially in the Center's early years.

In addition to seeking agreements with a variety of organizations and agencies for the loan of staff during its organizing phases, the Policy Committee also unanimously urged that the Center consider the cost savings advantages of a management contract with the National Health Council, Inc. to provide basic services and administrative systems during this period.

In recommending a diversified and balanced pattern of private support, the Policy Commitee suggested that the Center should seek support from health, education, welfare and civic organizations and associations as well as from major corporations, labor unions and private foundations.

The Committee agreed that all financial supporters of the Center should be publically indentified in the Center's annual report. Supporters should be given significant opportunities to participate in the Center's policy development and special project activities either on an individual basis or through the formation of special purpose coalitions. Supporters also should be given formal opportunities for periodic review and assessment of its policies and performance.

In order to assist the Center in publicizing the origins of its design, the Policy Committee agreed that a generally readable version of the project's report should be prepared and widely circulated to project participants and potential Center supporters.

Efforts are currently underway to secure financial support for the Center. A committee has been formed to raise approximately $100,000 to support the continuation of work during a six month period in which the Center's Board will hold its first meetings, elect its officers and appoint committees, raise continuing support and select its President.

At the time of this report indications are that the required funds can be raised for the Center from private sources. Since these indications consist of private conversations they are not reviewed in this report. They have been reported in confidence to the project officer. In lieu of a full report on this aspect of contract work at this time, an addendum to this report on this subject will be prepared after the appropriate commitments have been made by the Center's officials.

IV. EXTERNAL RELATIONSHIPS

A. Contract Requirments:

The Contractor will determine appropriate relationships between the National Center for Health Education and:

The H.E.W. Health Education Board
  (H.E.W. Intradepartmental Panel for Health Education of
  the Public)
The Bureau of Health Education
State and local governmental agencies
Universities
Private foundations
Industry
Volunteer organizations
Labor
Consumer Groups

B. Process of Accomplishment:

Major inputs to the findings for this portion of project work included:

1. Findings of a Study Group on Organization, Structure and Relationships; and

2. Contacts with hundreds of organizations and individuals by mail and conference participation representing all of the above categories (Tab IV)

The nature of the Center's possible relationships with outside organizations was explored in detail by the Study Group on Organization, Structure and Relationships. (Tab II-1, pp.18-24)

This Group's recommendations were accepted and further amplified by the Policy Committee at its third meeting. (Tab II-3)

Reactions of participants at the Conference on Organization and Funding were generally favorable to this portion of the proposed Center's design.

C. Major Findings:

The Policy Committee unanimously agreed that:

1. The Center's relationships with other organizations will be both extensive and diverse. In these circumstances, the mechanics of maintaining formal membership relationships would be excessively burdensome and relatively meaningless to the achievement of the Center's objectives. Therefore, a membership association between the Center and cooperating organizations would not be desirable.

2. The Center's goal is to facilitate cooperating organizations to adapt to one another's needs, values, goals and constraints in such a way that:

- their mutual needs and stake in general health maintenance becomes a shared national awareness;
- efforts to improve health practices become an internalized high priority for each individual organization's programming; and
- the need for some superordinate, cooperative health education policy and program development is recognized as inherent to the achievement of individualized goals and objectives.

3. The Center should be an advocate and resource responsive to the needs and perspectives of all its many cooperating organizations, agencies and groups.

4. The Center's capability to form continuing cooperative relationships with external organizations, and to involve them effectively in its policy and strategy design processes is critical to its ability to accomplish its goals and to achieve significant national impacts for a comparatively modest cost.

5. The Center should begin building its base of support and endorsement with a relatively small number of key national organizations representive of a diversity of interests and expertise. From this base it can then develop its relationships with an increasing number of organizations and agencies by involving them in the development of special purpose coalitions, by responding to their requests for assistance, and by selecting individuals affiliated with them for appointment to project teams or invitation to conferences and meetings, etc.

6. It is not expected that the Center will seek to develop routine continuing relationships with state and local organizations in its initial organizing phases. The Center later should begin to develop such relationships primarily through response to individual requests for assistance informational exchanges and reporting,, and through specific special purpose projects which involve state and local entities on a selective basis.

7. Organizations who contribute to the Center's financial support should be described as 'Sponsors' in Center publications and communications.

8. Organizations and groups who may not be able to support the Center financially should be given the opportunity to formally signify their support of the Center's goals and policies either in general or in particular instances. Such organizations should be listed as 'Endorsers' after formal action of the Center's and the respective agency's policy body.

9. All organizations, groups and individuals who participate in Center activities, advisory groups, and projects should be listed in relevant reports as a routine procedure in order to maintain and reflect the openness of the Center's decision-making processes.

The Policy Committee agreed that the National Center's primary focus of attention should be on the needs and opportunities for improvement of private sector health education efforts.

Obviously, however, the private sector's needs are not completely separate and distinct from those of public programs. The Committee saw the Center as providing leadership and policy guidance to the public as well as the private sector in the exploration and development of policy guidance for controversial issues in consumer health education.

In particular, the Committee saw the Bureau of Health Education and the National Center as complementary organizations which should share a common mission and goals but which would be distinguished by the public and private natures of their operations and constituencies.

The Committee agreed that the mutually facilitative relationship which exists between this project and the Bureau should serve as a model for the relationship of the Center with the Bureau. Acting as a focal point, the Bureau can provide the Center with orderly access to all of the scattered federal programs which would represent an enormous resource drain were the Center to attempt to maintain relationships on a one to one basis. Similarly, the Center should be able to serve the Bureau as a referral source to particular programs and findings within the diversity of fragmented private sector efforts.

The Committee also stressed the opportunity a close working relationship between the Center and Bureau could offer for more effective and efficient research and demonstration results developed through concerted, cooperative planning and implementation of projects which combine public and private resources to achieve shared objectives.

The Committee saw most of the Center's other relationships with outside organizations as highly variable. They emphasized that the primary criteria determining the extent and nature of the Center's relationships with any given agency or category of agencies should change depending on the types of problems or needs receiving highest priority at any given point in time.

The Policy Committee saw the Center as managing an open, structured problem-solving process which would encourage participation by a wide variety of external organizations, groups, sources of expertise, and opinion leaders at the points most relevant to their interests and potential contributions. They suggested that, for most situations, such a process would involved:

1) Needs Identification and Problem Exploration:

   To include the detailed examination and exploration of the nature, scope, magnitude and specific dimensions of the situation requiring policy quidance or action strategies with special emphasis on the views of consumer groups and their representatives and of the various practicing professionals who directly service consumer needs.

2) Knowledge and Resource Exploration:

To include the review and analysis of the 'state of the art,' i.e. the theoretical base and tested results of existing approaches to meeting the identified needs; and the review and analysis of the resources required to implement alternative action plans, i.e manpower, material, facilities, funding, organizational systems, etc. Participation in this stage would generally include representation from the relevant academic fields, providers, and other resource controllers.

3) Development of Strategy or Policy Outline:

To include review and comment by a wide variety of interested organizations, groups and individuals of a synthesis of the findings and recommendations concerning the areas of difficulty or deficiency identified and alternative options for their resolution.

4) Development and Implementation of an Action Plan:

To include the detailed development of policy statements, strategies and/or specialized research or test projects based on the suggestions and comments of cooperating agencies and their agreements to participate in further work effort.

5) Testing and Evaluation;

6) Spin-off and External Implementation.

Suggesting that this project had used an approach to plan development similar in concept to the types of policy development processes the Center might employ, the Policy Committee recommended that the types of organizations which had been contacted in the course of this project (Tab IV) were representative of those with which the Center should early seek to establish some form of continuing communication and cooperation.

V. IMPLEMENTATION

A. Contract Requirements:

The Contractor will develop a series of action steps required to bring the Center into existence with approximate scheduling and time for each step.

B. Process of Accomplishment:

Major inputs for this portion of project work included:

1. Recommendations of Study Group on Organization, Structure, and Relationships;
2. Recommendations of T. Schmidt and Associates on Organizational Form;
3. Recommendations of Conference on Organization and Funding;
4. Actions by the Board of Directors of the Health Education Research Council, Inc.

After considering a variety of options, the Study Group on Organization, Structure and Relationships recommended that the Center be created as a free-standing organization. (Tab II-1)

At its third meeting, the Policy Committee reviewed this Study Group's findings on organizational auspice and unanimously endorsed its recommendation. (Tab II-3)

An independent consultant, Terry Schmidt of T. Schmidt and Associates, was contracted to review the primary considerations affecting the selection of organizational form for the Center as a free-standing organization. (Tab II-5)

Two organizations whose purposes were to improve health through educational means and which were already established as federally tax-exempt 501 (c) (3) corporations offered to provide the corporate nucleus from which the National Center for Health Education could be established.

Participants at the Conference on Organization and Funding generally agreed to the immediate desirability of creating a National Center for Health Education, and strongly urged that action to accomplish this goal be initiated without further delay. They generally agreed that it would be impossible to develop financial support commitments until or unless the source which would be legally responsibile for bringing the Center into being could be identified. (Tab II - 7)

At its fourth meeting, the Policy Committee unanimously agreed to a series of actions concerning the immediate creation of a National Center for Health Education. (Tab II - 8)

Final determinations on the steps which would follow the project's termination were agreed to at the Policy Committee's fifth and final meeting. (Tab II-12)

Actions by the Health Education Research Council, Inc. to become the National Center for Health Education are reviewed under Tab IV.

C. Major Findings:

The Policy Committee unanimously agreed that:

1. The National Center for Health Education should be a free-standing, non-profit organization.
2. The Health Education Research Council, Inc. should be encouraged and supported to take those actions required for it to become the National Center for Health Education and to implement the proposal developed by this project.
3. With some additions, as a whole the Board members nominated by the Subcommittee of the Policy Committee and of the Health Education Research Council reflect the kinds of abilities and linkages recommended for the Center's Board.
4. The organizing committees, staffing pattern and budget recommended by another Subcommittee on Staffing and Budget also reflects the kinds of staffing requirements and expenditures the Center should consider for its first year of organizing and program development.
5. The Center should adopt a general statement of mission, objectives, functions and structure along lines developed and summarized by this project. In addition, it should select some high priority problem areas and develop illustrative specific project activities to be circulated to potential funding sources.
6. The Center should also consider the advantages of entering into a management services contract with the National Health Council, Inc. for its organizing phase of operation.

As a committee and as individuals the Policy Committee fully supports the proposal developed by this project and are willing to assist the Center in its implementation.

The steps required to bring the Center into existence have been taken and should shortly be completed. The next steps required to bring it to operational status include:

1. Election of officers; appointment of committees and recruitment of staff;
2. Development of initial program objectives; and
3. Development and initiation of full scale fund raising campaign.

Plans for the support of these activities during an interim period of 6 to 9 months have been developed and are being implemented by the Health Education Research Council with the assistance of the National Health Council.

VI. EVALUATION

A. Contract Requirements:

The Contractor will provide an analysis and evaluation of findings and recommendations as to their appropriateness, feasibility and practicality.

B. Process of Accomplishment and Major Findings:

Major inputs to this portion of project effort include:

1. Findings of Functions Mail Survey;
2. Findings of Conference on Organization and Funding; and
3. Reactions of Policy Committee and Study Group Members.

The project's findings and recommendations were developed from an evolutionary process of suggestion, review and refinement. At each step in the process, outside groups were given opportunities to review prior findings and suggest alterations. To date no major disagreements have emerged concerning the principal findings and recommendations of this project. As the record of each step in this developmental process shows, there has been a remarkably high level of supportive agreement.

Among those participants most actively engaged in the Project's work, i.e. the Policy Committee and Study Groups, support for the the recommended Center design has been unanimous. A very large percentage of those less directly involved have also expressed strong support of this proposal.

The best indication of the feasibility and practicality of the project's findings is the rapid progress being made toward their implementation. This progress is reflected in the materials on actions by the Health Education Research Council included under Tab IV.

RESOLUTION OF
THE NATIONAL HEALTH COUNCIL BOARD OF DIRECTORS
SEPTEMBER 18, 1975

Whereas, the National Health Council and its Member Agencies have been actively involved in recent national developments in the field of health education of the public, including the 1971-73 President's Committee on Health Education and the just-completed Federally financed study by NHC of the feasibility of a "national center for health education"; and

Whereas, the Board of Directors of the NHC and Member Agencies recognize the pressing need for a catalytic force in the broad field of health education of the public to reinforce and augment agency efforts; and

Whereas, as a natural outgrowth of the recommendations of the President's Committee on Health Education and the NHC feasibility study, there has been established a free-standing National Center for Health Education under the guidance of a distinguished Board reflecting a wide range of involved interests, both consumers and providers, and including Member Agencies of the NHC; therefore,

Be It Resolved:

The Board of Directors of the National Health Council recommends that each Member Agency of the National Health Council promptly express a firm public commitment of support for the concept of health education of the public and for the National Center for Health Education; and

Be It Further Resolved;

The Board of Directors of the National Health Council recommends to Member Agencies that their support of the National Center for Health Education take the form of program participation and cooperation, assignment of personnel, and financial contributions and contracts.

TOWARD HEALTH IMPROVEMENT

A design proposal
for a
National Center
for Health Education

Health education of the public–the potential

By whatever measurement, be it statistical assessment or opinion sampling, improved and more accessible medical care does not in itself assure better health. Providers and consumers alike have come to realize that health, or the lack of it, is as much a function of personal lifestyle and attitude as it is the treatment of sickness and injury. Of course, there are other factors at play here, like natural disaster and heredity, but we have little or no control of these elements.

Medical services will continue to be the individual's most important route to recovery. Day-to-day behavior—living habits if you will—registers equally important in much more neglected aspects of the total personal health picture—promotion and prevention.

Current health statistics point up the importance of placing greater responsibility on the individual for his or her own health. In particular, the nature of the leading causes of death in this country—cardiovascular diseases, cancer and accidents—highlight the need for increased personal involvement as well as medical intervention and/or invention.

Inherent in this increased responsibility is a proportionate increase in individual knowledge. To lead healthier lives Americans must be better educated and better motivated to make those daily decisions—take those daily actions—which individually and collectively, directly and indirectly, improve their chances for a long, disability-free existence. In essence, this is health education.

Historically, however, efforts in this country towards the health education of our citizenry have not carried much importance on the national agenda. At best, they've hardly compared to the priorities given the education of the health professional and progress in medical technology. We now know that improved health services made possible as a result of advances in medical expertise and technology have a limited impact on morbidity and mortality. The equation is fulfilled only when the individual takes a more active interest in his own well-being.

Although extant health education techniques have not been fully successful, many individuals and organizations do a good job at raising the level of personal health awareness. Health educators, professional and voluntary health agencies, insurance companies, practitioners and all levels of government provide invaluable and ongoing services in this area. Nevertheless, even they are cognizant that current efforts—which in many cases are limited to information dissemination—are fragmented and haphazard: a public service advertisement one week, a newspaper article another, a lecture now and then from the doctor. Moreover, there is no instrument or central stimulus to guide an effective national health education effort.

Why a National Center for Health Education?

THAT the field of health education is fragmented, uneven in effectiveness, indeed, that we are not succeeding to the extent possible, stands bleak testimony to the need for some form of immediate and concerted action.

It was concern for these shortcomings that prompted formation of a President's Committee on Health Education in September, 1971. Under the direction of Joseph C. Wilson and, following his death, R. Heath Larry, this distinguished group of citizens (see page 21) for two years studied the "state of the art" in health education. Through seven subcommittees, eight regional hearings and one national forum, among other means, the committee solicited input from hundreds of individuals and organizations in developing its recommendations aimed at "raising the level of health consumer citizenship."

In its final report, the committee stated that "the needs problems and opportunities in health education are so great, so urgent and so complex that progress will depend on a long-term, major commitment in both the public and private sectors." The group's principal recommendation, therefore, was twofold: that is, creation of two, separate but complementary national focal points, one within the federal government, the other, outside it.

The former, the committee maintained, would work with all federal agencies to help make the government's involvement in health education more effective and more efficient. The latter would be a private nonprofit organization financed by both private sources and federal government. "[At present] No agency inside or outside of government is either responsible for or even assists in setting goals, maintaining criteria of performance or measuring results. . . . The nation needs a National Center for Health Education to stimulate, coordinate and evaluate health education programs. . . . The overall objective of the National Center would be to improve the health of the American people through health education . . . "

History of the project

FOLLOWING receipt and subsequent study of the report, the Department of Health, Education, and Welfare agreed with the Committee recommendation and in 1974 established a Bureau of Health Education under the aegis of the Center for Disease Control in Atlanta. Around the same time, a contract was awarded by CDC to the National Health Council to explore in detail the feasibility of a complementary private sector approach.

The National Health Council was a logical choice. The fifty-four-year-old membership organization of some seventy major voluntary and professional agencies in the health field (see inside back cover) would offer a unique opportunity to involve virtually all segments of the private health community. CDC charged the Council to build upon the work already accomplished by the President's Committee by reaching out to a larger sample of organizations and individuals, including those outside NHC membership. Specifically, among those contacted would be educational institutions, health education and other interested professional associations and voluntary organizations, government agencies, public media, private foundations, consumer groups, labor organizations, business, industry and insurance carriers. In brief, the Council would develop in a year's time a detailed plan for the proposed National Center by soliciting input from these groups through a series of conferences, mail surveys, study groups and consultations.

Meanwhile, the Bureau of Health Education within CDC would begin developing its own programs as well as identifying ongoing health education activities throughout the federal government. The Bureau during this same period would also monitor the National Health Council project.

From the outset of the project in June, 1974, the National Health Council held successfully to three basic rules: primarily, that its effort would build upon rather than duplicate the work of the President's Committee; secondly, that it would endeavor to involve a large, representative sample of the potential supporters and users of the proposed Center; and thirdly, that major disagreements among project participants concerning center objectives and functions would be resolved during the early going.

Central to the Council's approach was immediate appointment of a Policy Committee (page 22) to give direction, supervision and added resource to the project. Work sequence actually revolved around a schedule of committee meetings, held on five occasions and at various locations throughout the year.

During the first several months of contract work, all of the materials compiled or developed by the President's Committee were analyzed, updated and condensed for Policy Committee review. At the same time, through surveys and other contacts, the National Health Council confirmed that the need for a National Center for Health Education in the private sector had increased in the time since completion of the President's Committee work. Based on the Policy Committee's agreement with this finding, project work proceeded on the well-founded assumption that further evidence of need was not required. Since the conclusion was that such a Center was feasible, much of the project's effort, therefore, concentrated on refinement of a design, which encompassed the development of objectives, functions, management structure and funding sources.

What can a National Center do?

ALTHOUGH the project's 576-page final report contains a wide range of suggestions and recommendations concerning the Center's objectives, program activities and organization, it also incorporates a specific design as proposed by the Policy Committee and endorsed by the National Health Council Board of Directors. The basic proposal calls for establishment of an independent, free-standing organization with a small, expert staff flexibly structured—i.e., having no fixed departmentalization—to respond to changing needs and priorities. Agreed was that a *matrix design* organization was preferable to the more traditional bureaucratic approach. That is, no bricks-and-mortar institution—the Center would act as an "energizer" and "facilitator" of the efforts of those who are already providing, or can be influenced to provide, health education to the public. The matrix concept thus offers efficiency in utilizing limited resources to accomplish diverse objectives and to serve varied constituencies.

In essence, this proposed design sees the Center as a non-bureaucratic, highly mobile health education problem-solving mechanism which would be dependent to a major degree on other organizations for input, resources, funding and the implementation of policies and projects.

The Policy Committee further recommends that the Center concentrate on "leadership functions" which no other agency can deliver to avoid duplication of other public and private resources. And while the Committee left to the Center's directors crucial decisions such as selection of specific program objectives and priorities as well as a site for the Center's base of operations, it did define through consensus and meticulous refinement seven major functional areas with which the Center should be concerned:

Consensus building and policy determination

OPEN, ongoing consensus building and policy shaping are conceived as central functions of the National Center for Health Education. The Center should bring together all organizations and agencies interested in health education. More specifically, it should provide the health care industry, education, labor, business, media, social, civic and consumer organizations with significant opportunities to debate, share and extract for their own use ideas and principles agreed upon as fundamental to health education program improvement.

The Center could, for example, provide meaningful opportunities for leaders of hospitals, health maintenance organizations, nursing homes and other institutions to exchange and debate proposals to further the health education of patients. Or, through Center initiatives, leaders of labor, commerce and industry, media and health care specialties could explore new health education approaches having positive impact on employee absenteeism and organizational productivity.

As the principal catalytic agent for health education of the public the Center should seek the development of national policy determinations based on its constituents' collective assessment of current needs, resources and program potentials.

National strategy design

ACHIEVING consensus and formulating policy are important first steps towards national health improvement through education, yet in themselves will not result in the creation or implementation of new or better health education programs.

Facilitated by the Center, a wide range of multidisciplinary expertise and public interests could join in building a composite overview of the national health scene, identifying critical educational priorities, assessing available resources and program approaches and developing innovative alternatives to presently fragmented efforts. Through a process of structured deliberation, opportunities for concerted use of resources and joint action by a variety of sources could then emerge.

The Policy Committee, aware of the difficulties which could be involved, anticipated that resolution could come only through an open yet structured process of debate and decision-making in which not only health and other scientific findings, but economic concerns, ethical dilemmas and the limits of popular acceptance are explored.

Health education advocacy

WITHIN the field of health education there are many voices which speak in behalf of professional interests concerned with specific disease entities and efforts to reach particular target groups, but none which speak for the field as a whole.

Also, the problems impeding achievement of substantial increases in the allocation of resources to health education are technically and politically complex, requiring a broader gauged approach than is currently possible.

The National Center should serve as an informed advocate for health education to energize those who allocate resources and those who must play a more active role in the provision of health education to the public. Among the ways in which this advocacy role could be pursued would be by providing expert testimony to legislative and other policy-making bodies, by convening coalitions in support of health education programs, and by building increased public awareness of health education achievements and needs.

Data base development

AT PRESENT, the many information sources concerning health education needs, resources, methods and evaluations are scattered and not easily accessible to program planners or practitioners. On a selective basis, the Center could improve the availability of such data by aggregating the output from various systems.

Experience in tracking down information would enable the Center to provide referrals to those seeking similar data. At the same time, the Center could augment retrieval and accessibility by encouraging usage of more uniform data collection systems and techniques.

The Center should also solicit more valid and reliable information in order to assess consumer health education needs. This would include knowledge of relevant epidemiologic, behavioral and program patterns. Such an undertaking would require evolutionary development. For the present, it is anticipated that the Center would work with other institutions which already have sophisticated data handling capacity.

Technical assistance

ONE OF THE pressing problems in health education is the slow and uneven application of knowledge —well established principles as well as innovative methods and technological advances.

The Center should accelerate the acceptance of improved methods and programs through establishment of a system of technical assistance and training. It could, for example, make available either borrowed expertise or its own staff in helping national, state and local groups plan, implement and/or evaluate their health educational efforts.

In addition, the Center could on request identify individuals and groups with special skills, knowledge and experience. Drawing upon the talents and experience of the many organizations who are doing effective work in health education, it could develop a cadre of consultants to serve programs in need of assistance. Also, it could assemble and disseminate technical materials, provide practical and tested models, instruments and procedures for health education and assessment.

Evaluation and demonstration

In pursuit of its objective to improve the state of the art, the National Center should encourage research and development in the health education field. New programs and technologies could result from models designed by Center-sponsored coalitions and consortiums. The Center should stimulate development and use of techniques to measure the appropriateness, acceptability and effectiveness of these innovations.

Rigorous evaluation techniques should also be applied to ongoing program activities as well as applications for financial support. In addition, self-evaluation should be an ongoing Center function, applied to selective testing of all aspects of internal operations.

The Center should continually communicate its experience; it should analyze, summarize and share with constituents as quickly as possible recommended models, components, program and evaluation approaches.

Governance

AS AN INDEPENDENT, nonprofit organization based in the private sector, the Center should be governed by a relatively small—approximately twenty-five—broadly representative board of directors. The selection process, at least initially, would involve canvassing organizations interested in the work of the Center, with screening by a small, external nominating committee. Members of the Board would serve as individuals and not as representatives of the Center constituency. In addition, terms of office would be staggered to allow sufficient overlap and continuity in policy direction.

Composition of the board should reflect a wide range of competencies and experience, and should include individuals from the following fields: health education, health care services and delivery, general education, consumer affairs, mass media, business and industry, planning and organizational management, and private and public finance. Collectively, the board should incorporate a diversity of personal backgrounds and interests which would assure not only expert guidance but acceptance of findings and recommendations by those who would be called upon for implementation.

Included among the principal functions of the board should be policy and strategy design determinations; center program direction; financial policy guidance, including basic funding, budgeting and resource allocations; external liaison and representation; and selection of the chief executive officer as well as appointments to committees and task forces.

As a primary resource for special committees and study groups, the board of directors should have an advisory panel of approximately 200 professionals selected like board members, on the basis of individual competencies and experience.

Organization and staffing

ALTHOUGH the matrix concept of organization calls for a strong executive arm, it opposes bureaucratic subdivisions or departments. Rather, suggested by the matrix design is the organizational capability to convene teams for specific projects, dispersing these ad hoc groups when the projects are completed.

Such organizational form allows a smaller permanent staff, flexible use of that staff as well as use of outside resources on a project by project basis.

In fact, the interface which separates the Center from its external, constituent organizations is extremely permeable in both directions. Accordingly, while constituents could be tapped for resources and expertise they should make use of Center staff and resources.

The matrix pattern would similarly influence internal staff make-up and operation, stressing ad hoc teamwork. Initially, core staff of the Center would be small in number and would reflect program design, management, group process and communications skills. Board and special committee members, loaned staff and outside consultants would be utilized as supplemental sources of manpower.

At the outset, sophisticated hardware and associated information systems required by the Center would be supplied by contract. As the Center develops, it would avoid direct acquisition of such equipment whenever possible in order to maintain program flexibility and to encourage spin-off of project activities once testing and evaluation have been completed.

Perhaps most important in terms of organization, however, is how the Center relates to its various constituents. A traditional membership relationship would not serve any useful purpose and may even inhibit achievement of objectives. Thus, problems of representation, voting power, dues collection, dues allocation and similar facets of traditional membership structures should be avoided. The Center's success would therefore depend on not only the openness of its policy and decision-making process, but the participation on an ad hoc basis of a wide constituency.

Funding

THE CENTER'S financial base should be primarily in non-public sources. Among potential supporters (see diagram) in the private sector are foundations, voluntary and professional health organizations, labor and industry—particularly insurance and pharmaceutical companies. Obviously, specific income and expenditure projections would be inappropriate until some of the more critical elements of the Center's design are agreed upon by the board of directors. As a working premise, the Center should anticipate a first through third year budget level of at least $1 million to support its organizing phase.

NCHE Project Chronology

DATE	EVENT
9/14/71	Committee on Health Education appointed by President of the U.S.
3/20-22/72	National Health Forum on President's Committee Preliminary Report
9/25/73	Committee on Health Education presents Final Report to the President
10/1/73	Secretary, DHEW, appoints Task Force
12/21/73	Task Force recommends creation of a Bureau and contract for feasibility study
5/24/74	NHC awarded contract to develop a practical plan for a National Center for Health Education
6/14/74	Representatives of NHC member agencies meet
9/2/74	Survey of 250 participants in eight PCHE Regional hearings
9/10/74	Policy Committee appointed
9/24/74	U.S. Bureau of Health Education created
10/29-31/74	First Policy Committee meeting
12/4-5/74	Functions Conference and Second Policy Committee Meeting, Northbrook, Ill.
1/23/75	Meeting of Study Group on Human and Technological Resources
1/27-28/75	Meeting of Study Group on Organization, Structure and Relationships
1/30-31/75	Third Policy Committee meeting
2/3/75	Questionnaire on proposed functions mailed to 700 organizations and individuals
3/1/75	Preliminary Project Report submitted to C.D.C.
3/15/75	Preliminary Report presented to representatives of NHC member agencies; NHC directors endorse outlined Center concept
4/17-18/75	Conference on Organization and Funding, Alexandria, Va.; Fourth Policy Committee Meeting
5/7/75	Subcommittee on Budget & Staffing
5/16/75	Subcommittee on Center Board Nominations meeting
6/13/75	Final meeting of Policy Committee
6/20/75	Annual Meeting of board of directors, Health Education Research Council, Inc. Unanimous agreement to change name to N.C.H.E.; election of new board members and adoption of bylaws amendments
8/19/75	NHC Final Report to C.D.C.
10/1/75	First Meeting of NCHE Board

President's Committee on Health Education

R. Heath Larry, *chairman*
U. S. Steel

Walter J. McNerney
Blue Cross Association

Joseph A. Beirne
AFL-CIO

Leroy E. Burney, M.D.
Milbank Memorial Fund

Joy G. Cauffman, Ph.D.
University of Southern California

M. Alfred Haynes, M.D.
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John Alexander McMahon
American Hospital Association

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A. C. Nielsen Company

Joseph T. Painter, M.D.
Ledbetter Clinic Association

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Corinthian Broadcasting Corporation

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Metropolitan Life Insurance Company

Scott K. Simonds, Dr.P.H.
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J. Henry Smith
Equitable Life Assurance Society

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Marian V. Hamburg, Ed. D.
New York University

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Harry Schwartz
Columbia University

G. Keith Thwaites
American Heart Association

Earl Ubell
NBC-TV News

D. Douglas Waterstreet
National Association
for Mental Health, Inc.

Wallace Ann Wesley, Hs. D.
American Medical Association

Conference on Center Functions

DISCUSSION LEADERS:

National Strategy Design
Scott K. Simonds, Dr. P.H.

Health Education Advocacy
Eugene Guthrie, M.D.

Consumer Needs Identification
Marcia Pinkett-Heller, M.P.H.

Identifying Existing and Needed Resources
William Carlyon, Ph.D.

Fostering Private Sector Cooperation
Walter G. James

Guidance for Program Planning and Assessment
Irwin M. Rosenstock, Ph.D.

Consultation
Joan Wolle

Information Exchange and Referral
Beverly Ware, Ph.D.

RECORDERS:
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Daniel Sullivan
Anna Skiff
Lois G. Michaels
Amanda Beck, Ph.D.
Susanne M. Lee
Clayton Medeiros

Study Group on Human and Technological Resources

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consultant

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Educational Testing Service

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Daniel Sullivan
Health Education Reports

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National Health Council, Inc.

Earl H. Cunerd, *president*
United Cerebral Palsy Associations

Gerald B. Greenwald, *president-elect*
Arent, Fox, Kintner, Plotkin, and Kahn

Robert C. Long, M.D., *immediate past-president*
private practice

Thomas P. Carpenter, *vice president*
National Council on Alcoholism

Walter J. McNerney, *vice president*
Blue Cross Association

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E. I. du Pont de Nemours & Company

Harold H. Wilke, D.D., *secretary*
United Church of Christ

John J. Gardiner, *treasurer*
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NATIONAL HEALTH COUNCIL, INC.

American Association for Comprehensive Health Planning
American Association for Respiratory Therapy
American Association of Blood Banks
American Cancer Society
American College Health Association
American Dental Association
American Diabetes Association
American Foundation for the Blind
American Heart Association
American Home Economics Association
American Hospital Association
American Hospital Supply Corporation
American Lung Association
American Medical Association
American Medical Student Association
American Medical Technologists
American Medical Women's Association
American Occupational Therapy Association
American Optometric Association
American Pharmaceutical Association
American Physical Therapy Association
American Podiatry Association
American School Health Association
American Social Health Association
American Society for Medical Technology
American Society of Allied Health Professions
Association of Medical Rehabilitation Directors and Coordinators, Inc.
Association of Schools of Public Health
Blue Cross Association
Committee to Combat Huntington's Disease
Cystic Fibrosis Foundation
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Epilepsy Foundation of America
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National Dairy Council
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Social Security Administration
Society for Public Health Education
Student National Medical Association
The American National Red Cross
The Arthritis Foundation
The Equitable Life Assurance Society of the United States
The National Foundation–March of Dimes
The Prudential Insurance Company of America
United Cerebral Palsy Associations
United States Department of Agriculture
United States Office of Education
United States Public Health Service
United Way of America
Veterans Administration

Mr. ROGERS. Thank you very much for a most helpful statement. The committee congratulates you and your associates on the progress you are making on your own initiative.

Mr. GREENWALD. Thank you.

Mr. ROGERS. We are very pleased to hear of this and I know the committee will benefit from the advice that you have given us.

Mr. GREENWALD. Thank you.

Mr. ROGERS. Are there any questions?

Mr. CARTER. No questions.

Mr. ROGERS. Thank you so much.

Now we have the National Center for Health Education panel. I believe Mr. Fairleigh Dickinson cannot be present, as I understand it, because I think he is receiving medical treatment. Chancellor Carter of Atlanta University Center, Atlanta, is present, and also Evalyn Gendel, associate director of the Bureau of Maternal and Child Health, Kansas State Department of Health and Environment, and Robert L. Johnson, vice president, University of California.

We welcome you to the committee and you may proceed as you desire.

STATEMENTS OF CLARENCE PEARSON, PRESIDENT PRO TEM, NATIONAL CENTER FOR HEALTH EDUCATION, IN BEHALF OF FAIRLEIGH DICKINSON, JR., CHAIRMAN OF THE BOARD, NATIONAL CENTER FOR HEALTH EDUCATION; LISLE C. CARTER, JR., MEMBER OF THE BOARD AND EXECUTIVE COMMITTEE, NATIONAL CENTER FOR HEALTH EDUCATION; AND DONALD J. MERWIN, DIRECTOR, PLANNING AND ADMINISTRATION, NATIONAL CENTER FOR HEALTH EDUCATION, IN BEHALF OF EVALYN S. GENDEL, M.D., MEMBER OF THE BOARD AND EXECUTIVE COMMITTEE, NATIONAL CENTER FOR HEALTH EDUCATION

Mr. PEARSON. I am Clarence Pearson, president pro tem of the National Center for Health Education, and I must regret 10 minutes before the hour scheduled I received a call from a close associate of Mr. Dickinson, and he sincerely regrets he cannot be here because he looked forward to meeting with your committee.

Lisle Carter, from Atlanta University, of course is here with us today, and Evalyn Gendel and Dr. Johnson also regretfully say they could not attend, but we have Dr. Gendel's statement here that one of my colleagues is going to read—Don Merwin.

But I would like to read Mr. Fairleigh Dickinson's statement here—summarize it for you.

Mr. ROGERS. If you could summarize it, it would be helpful.

Mr. PEARSON. I am speaking in the name of Fairleigh Dickinson, Jr., who some of you know is chairman of the Board of Becton, Dickinson and Co., manufacturers of medical laboratory and industrial safety products.

However, his testimony here today is in his capacity as chairman of the board for the National Center for Health Education, and I will read it as he would have, had he been here.

"The National Center for Health Education was created in response to the recommendation of the President's Committee on Health Education that there was need for a focal point in the private sector to energize, upgrade and promote efforts in this crucial area.

"It is a new organization; the Board of Directors held its initial meeting on October 1 of this year. The membership of the Board reflects the broad diversity of groups, both lay and professional, who are currently involved or should be involved in health education of the public. At its next meeting, scheduled for mid-January, the Board will consider nominations which are intended to make its base of support and expertise even broader. For the present membership, I call your attention to the list which is before you.

"The National Center for Health Education has as its mission improvement and expansion of the contribution of the private sector to health education of Americans and came into being as the result of initiative in the private sector. A blueprint for its organization, its structure, and the functions it will perform was developed by the National Health Council under a contract with HEW's Center for Disease Control, but our organization is freestanding and independent of any pre-existing agency, either governmental or voluntary. It is incorporated in the State of New York under its not-for-profit corporation law, and is wholly dependent on contributions from the private sector for its support.

"Why have the 20 distinguished Americans who make up the Board over which I have the honor to preside agreed to give generously of their time and energy to make the National Center for Health Education a success and why are we receiving encouraging evidence of the willingness of corporations, of unions, and of voluntary and professional health organizations to give financial support to our efforts? I believe that it is because they share with me the conviction that many of the major causes of sickness and death can be affected and even prevented by individual behavior.

"They also believe, as I do, that Americans need to be enabled to regain control over their own health.

"They need not only to realize the damage being done by inappropriate health habits, but also to be helped to do something positive about it.

"Everyone knows smoking is an important factor in today's health problems. Yet, more people, especially teenagers, are smoking than ever before. We have the means to control polio, diphtheria, tetanus, and other such diseases, and yet the proportion of preschool children adequately protected has dropped to the lowest level in a decade. Poor eating habits damage health, yet there are a great number of overweight people among us.

"Why do some 50,000 people die each year in automobile accidents? Why does 1 out of 3 patients not follow doctors' orders? Why is venereal disease at the highest level ever recorded in this country?

"Why are so many people alcoholics or drug addicts? Why are so many being disabled by diseases that are preventable and curable, or dying prematurely from causes that could have been controlled? Why do most people get their health advice from TV commercials?

"Why, in short, hasn't the finest medical technology in the world been better able to control the controllable and prevent the preventable?

"The National Center for Health Education wants to find the answers to these and other questions about why people act the way they do regarding their own health and safety. And we want to find solutions through health education programs that attack the problems in innovative ways, with resources far greater than have ever before marshalled for the task.

"Unfortunately, health education in this country today is fragmented and uneven. It is sadly neglected in the schools, in homes, at places of employment, in hospitals and doctors' offices. Society at large has failed to do everything it can to create a clean and healthy environment. Far too little is spent in and out of Government for health maintenance and promotion.

"The Center hopes to develop a national strategy for health education. This will include activities to identify and evaluate what is already being done by organizations and agencies at every level, as well as to foster research and innovative demonstration programs designed to better achieve health education goals. The high priority of this effort is further underscored by the inflation of health costs and an already overburdened health care delivery system.

"We cannot hope to control costs, or improve access to needed care, unless the means to bring health knowledge to individuals are greatly improved, and people are enabled to help themselves have good health.

"In other words, Americans are going to keep spending more and more to cure diseases until they recognize that better health habits might have prevented or minimized the impact of those diseases in the first place.

"The National Center for Health Education has a commitment to help Americans overcome the barriers to the adoption of more healthful patterns of behavior. This must be done without threatening personal choice or freedom. It must be done because people want to do it in their own best interests, and, finally, it must be done in such a way as to improve the quality of life. If it is humanly possible through an all-out nationally unified effort to correct the deficiencies of health education and encourage people to take better care of themselves, the Center is determined to find the way.

"We will welcome the opportunity to undertake this challenging task in close cooperation with the Federal Government which also has major responsibilities in this area. We would be particularly pleased if the Congress of the United States could take formal note of the National Center and what it is endeavoring to do. But we are unswervingly dedicated to the principle that the major responsibility is that of the private sector—the voluntary health organizations, the professional societies, the mass media, the consumer groups, labor and industry.

"We are confident that the legislation you report to the floor will embody your recognition both of the importance of health education and of the vital role that can be played by our private sector-based National Center, including all those groups that I mentioned previously.

"We are deeply appreciative of the vision and initiative of the sponsors of the bills which you are considering today, and of the contribution they have made in bringing health education closer to the top of the national agenda where it belongs.

"We are also grateful for the opportunity you are giving us to place our views before you today, and will be happy to attempt to answer any questions you may have."

Mr. ROGERS. Thank you, Mr. Pearson.

STATEMENT OF LISLE C. CARTER, JR.

Mr. LISLE CARTER. Mr. Chairman, I don't have a formal statement. I have several brief remarks to read.

Mr. ROGERS. Certainly. That will be fine.

Mr. LISLE CARTER. Let me express again on behalf of my colleagues their regret in their inability to be here, particularly Dr. Gendel and Mr. Johnson. I was with them just last week when we agreed to come and testify, and I know of their determination to be here and only a series of coincidents, things involving weather and other circumstances, have prevented their coming.

My name is Lisle Carter. I am chancellor of the Atlanta University Center. These brief remarks are offered in my capacity as a member of the board and executive committee of the National Center for Health Education.

I would like to join in Mr. Dickinson's statement congratulating you, Mr. Chairman, Dr. Carter and the others for their authorship and sponsorship of bills in this neglected area of health education. Perhaps it is because of my many years in working in programs for disadvantaged that I see health education in a somewhat different light from the traditional one. I believe that one of the reasons for the relative ineffectiveness of much current health education is that it seeks to require people to do things which their economic circumstances or cultural patterns make it impossible or undesirable, as they find it.

My interest in support of the national center is based in large measure on my confidence that it can and will do more to be sensitive to problems of this kind.

I am determined, and I know that others on the board are as well, that the center will approach health education not just as a process of informing or persuading people what to do in order to be healthier, but also as one helping to remove the barriers which bar their way to healthier lives.

Although I have served in government and believe in the importance of major governmental activity in this field, I also believe strongly that government cannot and should not do the job alone.

Accordingly there are many issues, of the kind referred to in Mr. Dickinson's statement, that relate to the community development, to individual behavior and lifestyle about which citizens voluntarily can associate and agree to act—but about which government is not in a position to, and should not mandate action.

The National Center for Health Education is now a reality, Mr. Chairman. It is an organization, with strong leadership which I believe will become stronger with further additions to the board and by the hiring of a chief executive, that has the capability to stimulate much of the private initiative I think so essential in this area.

I hope that the important legislation which you are now considering will take into account the essential role of the private sector in health education, and within that sector, the potential of the national center.

Thank you.

Mr. ROGERS. Thank you very much.

I appreciate your statement and your thoughts, particularly your stressing the importance of having the private sector do as much as it can.

Mr. Merwin.

STATEMENT OF DONALD J. MERWIN

Mr. MERWIN. Thank you.

My name is Donald Merwin. I am director for planning and administration of the national center, but I am here today to summarize the remarks prepared by Dr. Evalyn S. Gendel.

Dr. Gendel serves as an associate director of the Bureau of Maternal and Child Health, in the Kansas State Department of Health and Environment, and she is the immediate past chairman of SIECUS, the Sex Information and Education Council of the United States.

However, these remarks, like those of the two previous speakers are made in her capacity as a member of the board and executive committee of the National Center for Health Education.

Dr. Gendel wanted to indicate to the committee she is particularly happy to appear before it because of her close and friendly association with her Topeka colleague, Congressman Roy.

She said, "As a member of the National Health Council's policy committee which developed the plan for a national center which you have before you, I am deeply pleased that it has evolved from a good, but somewhat vague concept into a potentially important force for the nationwide upgrading of the health education of the public.

"As a physician, I am all too aware of my profession's inability to make further substantial impact on the Nation's health, if people are not enabled to take better care of themselves.

"As a sex educator, I am painfully conscious of the many barriers to dissemination of knowledge and provision of opportunities for informed choice which the fragmentation and low-priority status of health education allow to block progress.

"As a citizen, I am appalled by the waste of scarce resources which delayed or inappropriate use of the health care delivery system creates.

"The National Center for Health Education has selected three vital areas for its initial program emphasis. It is conducting intensive reviews of patient education, of health education of workers and of opportunities for health education initiatives under the new health planning and resource development legislation.

"In each instance, the objective is not just more studies and more talk but the development of action programs in which a broad spectrum of organizations and interests can cooperate.

"The National Center for Health Education is a new organization, but it brings together countless years of experience in health education, communications, operations and other relevant areas. It is our firm intention to reach out to sources of leadership and creativity in both government and the private sector in order to make the center as potent and as constructive a force as possible in harnessing the great under-utilized potential of health education.

"We were gratified by the greetings conveyed by President Ford to the first meeting of our board of directors last month. His words summarized our own feelings about the center and I will close with them:

" 'The formation of this new center represents a commitment to health education on the part of private sector which is absolutely essential if the American people are to take better care of their health and make more effective use of the health services available to them.

" 'Only through a strong and continuing partnership between governmental and private resources, can we hope to promote better health for individuals, families and communities across the nation.'

"The President concluded by wishing the National Center for Health Education every future success.

"I am confident that the Congress will wish to take actions which will help insure that success through the development of the public-private partnership of which the President spoke."

Mr. **Rogers**. Thank you very much.

I think in view of the progress that you are making the committee might at least consider changes in the language of the bill, and I think it would be helpful if you could submit language to us that you would think would be appropriate along those lines.

Mr. **Merwin**. Mr. Chairman, we would be very happy to.

Mr. **Rogers**. Dr. Carter?

Mr. **Carter**. No questions; thank you.

Mr. **Rogers**. Let me just ask a couple of questions quickly about some of the matters in the bill.

For instance, what is your basic feeling on control of false and misleading advertising of health products?

Mr. **Pearson**. We haven't taken a position on it at the moment.

Mr. **Rogers**. Perhaps you could submit it for the record.

Mr. **Merwin**. I think one point on which the policy committee of the National Health Council, who developed a plan for the center, felt quite strongly was that the controls of false and misleading advertising—and indeed, any intervention with regard to the mass media—is a matter for which the private sector is a much more appropriate instrument or agent, that many people are seriously disturbed at the prospect of Government control of the content of the media.

That is true of advertising, which could be interpreted as misleading, because there are already controls in the broad sense, or over the question of violence or inappropriate programing for children, and one of the rationales for a strong private sector was the appropriateness of self-control, self-respect and pressure from within the private sector.

Mr. **Rogers**. What about publication of costs and quality information about the health system?

Mr. **Merwin**. There again the board of directors of the center has not yet had an opportunity to consider, but that was within the purview.

Mr. **Rogers**. If you have anything on these questions I think it would be well to submit something for the record, if you could.

For instance, how do you view package inserts for patients who use prescription drugs?

Mr. Merwin. Very good.

Mr. Pearson. Thank you very much.

Mr. Carter. What priorities have been established by the center for next year in regard to health education activities?

Mr. Pearson. Well, at our first board meeting they wanted some specific action and the program areas were selected. One was the health education of patients in medical settings, but the whole broad-base look at patient education and the most effective ways of doing it, and also what kind of criteria should be established for reimbursing by third-party payers for patient education.

The second program priority was in the area of health education in the work setting, health education of workers, not only about their own particular job but health education using that setting to educate them about things that occur in their community and, third, health education as it relates to the new planning legislation. How can health education plug in, and in different intervening points involve the citizenry in this planning process?

Those are the major areas and we have been charged, the staff has been charged with coming up with some appropriate plan of action by the next board meeting, which is the middle of January, and I must say they are working pretty fast to do this.

Mr. Carter. What do you anticipate your relationship will be with the Bureau in Atlanta?

Mr. Pearson. We hope that we have a relatively close relationship because I think we can't do this in a vacuum, even though we are mobilizing all of the private interests, so to speak. The Bureau of Health and Education has its priorities and I must say they are very closely related to the private sector priorities, and what we want to do is meld them together and come up with some national strategy which will meet the goals of both parties. It is that partnership concept.

Mr. Carter. In two of the bills there are certain provisions which I believe would strengthen the nonprofit private institution, link it to the Federal center, and which also provide for a degree of accountability. Also, 2 members of the board of directors of the private, nonprofit institution are to be appointed by the President.

Second, the institution would receive some Federal funds over 3 years, and also the institution would be subject to an annual audit and would be required to submit a report of its activities to the Congress and the President.

What do you think of these provisions, and what kind of linkage or communication do you see yourself maintaining with these Federal efforts?

Mr. Pearson. That is quite a probing question and I am not sure I can answer all of it because our board really haven't reviewed every aspect of that.

They have supported the bills in principle. We have felt that any Government links with the private sector, if they are through appropriations, for example, should be a heavier weight on the private money versus the Federal money—say, a three or four private funding versus one part Federal, and I think we would hope that there would be some linkages with the Federal Government spelled out, but I think we need more discussion on that.

Mr. **Merwin**. May I add to that that the board currently has instructed its nominating committee to submit additional names for inclusion for membership on the board, and its preliminary discussion certainly would welcome the naming of some governmental representatives to the board by the President, or by the Secretary or by Congress so that there is a receptivity to the idea of getting accountability through some formal linkage, some formal oversight.

Also, the board has approved the concept of some Federal contribution. As Mr. Pearson said, it would have to be in perspective less than the private sector contribution, and certainly feels that that contribution should be contingent on the center's discharge of its responsibilities; that there should be congressional review within 1 year or 2 of the center's accomplishments as a condition of the continuation of any Federal support.

Mr. **Lisle Carter**. I would like to emphasize that last point and another related to it.

I think we feel very strongly that this should be primarily a private initiative, although we think it is important to have linkage with the Federal Government and see participation in the Federal Government in the effort; so that we want to emphasize I think the private aspect of it.

Two, I think everyone is mindful of the difficulties in the field of health education, and a good deal is said about how much is still not proven about the effectiveness of what has been done. So that I think all of us are of a mind that we are not interested to just create another organization which gets some money, and then goes on for a number of years, and people suddenly say what has it done, what has it accomplished?

We think that the beginning of this should be an effort to try things out, to see how they work, to hold all of us accountable, to see whether this is something that really moves in some demonstrable way and contributes to making some changes.

Now, these things are not easy to measure and I don't want to seem to promise more than we would be able to produce either in substance or in measurable effects, because when you are dealing with something as diffuse as health education it may be over a long period of time before you really recognize the effects of that program. Even then they could be arguably subsumed in so many other things that are going on in the society. For example, in the Second World War the question came up—was it the tuberculosis screening program that did something about TB, or the improvement of nutrition of people that did something about TB during that period?

Nonetheless, I think there are some measurable things that can be discretely developed, that we ought to try in partnership together to work on, rather than launching into a huge commitment which might not necessarily pan out over time, and thus lead to greater scepticism about the future of health education.

Mr. **Carter**. Thank you very kindly.

Mr. **Rogers**. Thank you very much for your presence here today.

Our next witness is vice president of the Equitable Life Assurance Society of the United States, Mr. Howard Ennes of New York.

STATEMENT OF HOWARD ENNES, VICE PRESIDENT FOR HEALTH AFFAIRS, EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

Mr. Ennes. Thank you, Mr. Chairman, Mr. Carter.

My name is Howard Ennes. I am vice president for health affairs of the Equitable Life Assurance Society of the United States.

I appear before you today on behalf of the more than 300 insurance company members of the Health Insurance Association of America, and as chairman of our association's Committee on Health Education.

Because of its relevance to the complex subject under discussion, may I ask your indulgence to mention my personal credentials?

My professional background is in health education, with a master's degree from the Yale School of Medicine and experience at the Federal, the national voluntary, and local level in community health education. I am a past president of the Society for Public Health Education; past president of the International Union for Health Education; a member of the board of directors of the National Health Council; and a member of the initial board of the National Center for Health Education.

By their very nature, the member companies of the Health Insurance Association are deeply concerned for the well-being of all individuals in the United States. They and other insurers protect more than 182 million Americans—some 9 out of 10 of the civilian resident population—by one or more forms of private health insurance. We have a history of more than 40 years of growth in developing health insurance services for the American public.

Consequently, insurers, through our association and as separate companies, have expressed interest in programs and activities aimed at improving medical care services, and at effectively raising the level of health maintenance knowledge and skills of the public. As you are aware, we have done quite a bit in the overall areas of health care delivery and financing.

I must confess, however, that we have found the health education area rather frustrating—that is, until quite recently, for this new development of interest on the part of the Congress, and the creation of the new National Center for Health Education gives us real hope and a renewed sense of enthusiasm.

Insurance companies always have known they had an important stake in effective health education for a number of reasons:

First, health education has the potential to improve the environment in which health insurers must operate by helping to ease the pressures of cost inflation and the overuse and misuse of medical care services and facilities.

Second, health education has a very real potential for claims-cost savings—at least over a period of time—by encouraging positive health behavior and prevention, and thus reducing medical care expenditures and income lost as a result of disability.

Third, if health education can be made a marketable benefit, it can generate community interest, support, and participation in more effective health programs.

Fourth, and of utmost importance, health education can enhance the well-being of the consumer.

In the late 1960's, with these ideas in mind, our industry embarked on a significant and far-reaching course. Recognizing that there were shortcomings in the health care system in the Nation—including the generally neglected area of health education—we began an extensive nationwide examination: First to define problem areas; and second, to exert influence to create more soundly conceived and responsible systems to meet the needs of all Americans.

This examination proved a milestone in the history of private health insurance. It resulted in our 1969 report, "Health Care Delivery in the 1970's" which won warm approval by HIAA member companies. One of the major recommendations reads as follows:

> That the association and member companies take necessary steps to assist in the prevention of diseases and accidents, including the education of the insured consumer in sound health habits and the establishment of policy in advocacy of sound legislative proposals, the purpose of which is to prevent diseases and accidents.

The recommendation was quickly implemented. We appointed a committee to explore in depth the subject of health education and determine possible ways by which the business might relate to program needs in this area. What emerged was the recognition that the broad, complex, and amorphous nature of the subject required more than an independent effort on our part. Hence, in 1971, the insurance business encouraged the establishment of the President's Committee on Health Education, and welcomed the opportunity to participate in it. Two insurance company senior executives served as members of the President's committee. Insurers associations provided financing and, in addition, a number of insurance officials gave valuable personal staff time to the committee's study.

As you know, a major recommendation of the President's committee was that there be created a private, nonprofit National Center for Health Education to stimulate, coordinate, and evaluate health education efforts, as well as to conduct and stimulate research designed to find ways to persuade people to modify their lifestyle as necessary to better the quality of their lives. A further recommendation was that the National Center be jointly financed by private and public funds.

Both insurance company members of the President's committee—Mr. Charles A. Siegfried, then vice chairman of the board, Metropolitan Life Insurance Co.; and Mr. J. Henry Smith, then chief executive officer of the Equitable Life Assurance Society—enthusiastically supported those recommendations. They saw, however, a need for further clarification and development of the concept of the proposed Center.

Accordingly, over the past year or more, we worked closely with the National Health Council in helping the Council with its Federal contract charge to develop and describe the functions, structure, and organization of such a center. Mr. Greenwald spoke of that earlier this morning.

The National Center for Health Education is now a reality. It stands as a heartening example of what can be accomplished when there is recognition of a need and commitment to an idea, with initiative and willingness in both the private and public sectors to work together constructively. For our part, we in the insurance business stand ready to continue to work with this free-standing enterprise. We view it as an invaluable instrument in strengthening the health education efforts of both the private and public sectors.

I should report to you, Mr. Chairman and members of the committee, that the private insurers already have put their money where their mouths are. The HIAA board, just 2 weeks ago, voted a financial contribution to the Center, and several companies—including, I am proud to say, the Equitable—are providing startup funds.

Let me add, however, that by agreement with the National Center, the insurance contribution will be limited to a reasonable overall amounts, for there is a firm determination that no one source of funds—private or public—will be large enough to even give the appearance of undue influence over the Center's programs or policies.

The fact that there now exists a responsible and accountable National Center for Health Education drastically changes the situation from the time the bills before you were introduced. This is true in two respects.

First, the functions and purposes of the proposed federally chartered organization as set forth in several of these bills here and in the Senate—patterned as they were on the proposals of the President's Committee and the National Health Council study—are the very functions and purposes of the new Center.

Second, and perhaps more important, many of the assignments given in these bills to the Secretary of HEW could be better done—and probably more economically done—in an atmosphere different from that which inevitably exists when an effort is being stage-managed by Federal officials and paid for by Federal dollars.

I feel we should be very candid with ourselves on this score. Health education in practice requires a delicate balance between authority and persuasion. We are dealing, day by day, literally moment by moment, with subtleties and nuances of individual behavior and feelings. It is not a simple matter of "know the facts and they will set you free." There is so much we don't know, and yet so much we know but haven't put in perspective that we haven't used constructively.

Health education in action presents quite a series of dilemmas that calls for organized, consistent examination, demonstration, evaluation over a period of time, backed up with realistic resources. Yet if we are to mobilize the potentialities of the individual citizen to better deal with his own body and being in matters of health and in the use of the Nation's resources for medical care, we must acknowledge the awesome responsibilities placed on those who manage the effort. And I would call to your attention a comment in the Senate report on S. 1466, at page 33, that "to be effective, such action by a governmental agency may conflict with constitutionally guaranteed private freedoms."

In short, it is not simply a matter of avoiding duplication of effort and expenses, nor even a matter of efficiency. It also is a matter of roles and functions of the Federal Government, of the multiple elements in the private sector, and of the individual citizen.

This new situation presents us, I feel, with a timely opportunity for shaping a new and better way of working together, a way of blending and reinforcing the special characteristics of our American federal system in tandem with the uniquely American concept of voluntarism. This joint interaction would produce strengths greater than the sum of the separate efforts—a synergistic impact, if you will.

Perhaps we could try out some new ideas and processes in this area of health education of the public? It could be done on somewhat of an experimental basis, tested out, evaluated to see if there is a basis for larger scale efforts, and on what terms there might be continuing involvement of all parties concerned.

To illustrate: Take the idea of a "Federal focal point" which is addressed variously in each of these bills. Present activities should, of course, be strengthened. There should be a sort of "corporate staff office" at the HEW Secretary's level. This would concentrate on stimulating health education program development in all HEW.

Further, it could staff what might be thought of as an "interdepartmental council on health education" to be appointed by the President, and have participation from the Congress and executive departments and independent agencies.

Such a Federal Council or Board could advise the President, through the Secretary of HEW which might be Chairman, in formulating Federal goals, identifying and analyzing needs and resources, and devising a strategy to achieve such goals with respect to health education, information, promotion, preventive medical care services, and education in the effective selection and use of medical services.

The Council likewise could be useful in making certain that legislation be considered by the Congress should, where relevant, include provisions regarding health education. This type of review, and the reporting activities required of the Secretary as specified in some of the bills before you, is consistent with the health impact statements called for in the "National Health Care Act of 1975" (H.R. 5990). Such monitoring and standard setting activities are, it seems to us, appropriate roles for the Federal executive.

The Federal Council also could do something about providing effective health education for all Federal employees—a dereliction which the President's Committee pointed up. It does come with poor grace to tell others what to do when you haven't done it yourself.

This Federal Board could provide a means for effectively interrelating the governmental apparatus with the private sector. For example, there could be liaison members from the private sector to be selected by the President from lists proposed by the National Center for Health Education. In turn, congressional and Federal executive members could be named to the Board of the National Center on recommendation of the interdepartmental council. I believe the Center would be receptive to that idea.

Being realistic about the multiplicity of ideas and approaches suggested in these various bills as to how to carry out health education, what research to do, and the like—and taking into account the innumerable constituencies involved—it would seem prudent to proceed cautiously about mandating too many activities to the Federal machinery.

It seems to us that the new National Center for Health Education is an ideal way to approach the problem. It has the necessary breadth of constituency support and the potential for assembling the professional and technical competencies required. It is not burdened by the implications and ramifications of the Federal environment, and would be substantially more free and able to probe and test and discard.

If Congress would so direct, for example, the National Center could include in its overall program, specific assignments from the Federal interdepartmental council—perhaps on a contractual basis through HEW.

The National Center could provide a solid basis for formulating a national strategy for health education, providing detailed identification of needs, current activities, and gaps in services.

It could identify and quantify existing and needed resources—personnel, facilities, technology, financing.

Further, it could outline and initially develop specific action proposals—including community demonstrations, research topics, evaluation methodology, informational activities, school curriculum models, public and private organizational and administrative approaches for national, State, and local health education services.

The Congress could require that the Center provide a definitive report to the Congress and the President within, say, 2 years, as a basis for further congressional and Executive consideration and, if appropriate, legislative action.

Full accountability might be further enhanced even beyond the liaison arrangements and specific contracts. This could be done by congressional authorization of a Federal contribution to the core operating budget of the National Center. But this should be on a matching basis—perhaps one Federal dollar for each three from the private sector—and the total should not exceed $1 million Federal in any fiscal year.

This would have the effect of further stimulating professional and private support, and would help assure prompt and intensive action on a mutually supportive private/Federal basis. It would not, however, unduly tilt management and control.

We would suggest, however, a critical reevaluation in 3 years unless the report and recommendations specified in the proposed contract were to be considered unsatisfactory—in which case, earlier reevaluation would be in order.

If these ideas are helpful to you in your deliberations on these bills, we shall be very happy. Of course, we would be glad to help develop the concepts and ideas further if you so desire.

Mr. Chairman, whatever the future shape of the American health care system, we feel it is clear that we shall never escape the necessity—at least in a democracy—for an informed, participating citizenry. That is what health education is all about.

And for myself—and I believe for all my colleagues in the health education and the insurance fields—I thank you deeply for your interest and commitment.

Mr. Rogers. Thank you very much, Mr. Ennes, and we congratulate your company and your associate companies on trying to be helpful in the health education field.

I think it is important to have the private sector have a significant input.

Let me ask this. Would you think when a person goes to see a doctor and gets health education in a doctor's office, or a hospital, it would have a tendency to improve that person's health, and perhaps he might recover sooner? In other words, if one is told how to take their drugs and the importance of it, and so forth, does it help; have any studies been done on that that you know of?

Mr. Ennes. Yes, as a matter of fact, there have been a number of studies, not as many perhaps as necessary to be definitive, but a good many studies indicate that to the degree to which the patient is truly involved—and we are talking here about patient education where there is a defined situation, a relationship where the patient is involved, where the patient is informed, where there is a warm and caring relationship with the person providing service—yes, there is change and improvement.

Our problem, Mr. Chairman, is that patient education is an area of concern, and there is great need to improve activities in this area; but our real problem, I think, begins back long before that, where we have a problem of developing attitudes and feelings about the health relationship and the health responsibility.

Somehow or other, when one gets ill one becomes very dependent and wants to be told and be put into a situation that produces a result. Well, it doesn't always work out that way. We have a lot to learn, and yet there is a lot that is known and has been tried that we can build on.

Mr. ROGERS. From what I understand from some studies I know of, health education could be an important factor in perhaps even reducing the time a person needs direct medical care.

Now, if this is true, what do you think the attitude of the insurance companies might be with respect to including some payment mechanism for doctors, hospitals, and health care systems to provide the health education?

In other words, should this be a part of a health insurance policy?

Mr. ENNES. Our position on that is, yes, that it should be. The problem is defining what that is.

Mr. ROGERS. Yes.

Mr. ENNES. If you look at the definition of physician, you see the physician is a teacher. Unfortunately, he hasn't been doing his job in teaching his patient by and large. We are already paying for that service, Mr. Chairman. It is not being delivered. The question is really developing criteria.

I think Mr. Pearson referred to one of the three primary projects that the National Center for Health Education—less than a month old—already is working with, and that is this whole problem: What are the criteria for education within the inpatient and outpatient setting.

If we can find some—if the insurance business can find some basis among the professionals of defining what health education process and procedures are, we can work that into reimbursement formulas.

I challenge anyone to define what those procedures and definitions are at the present time. This is the gut problem.

Mr. ROGERS. I understand the difficulty. It is not easy to articulate these particular criteria, but I would think some thought could be given to that, and it shouldn't be too difficult, for instance, to say before you pay a doctor's bill that there must be a showing on the billing that the patient was instructed on how to take care of himself, how to take drugs, whatever the important points of taking care of one's self in this particular instance would be, which I presume the individual doctor could list as proper education.

If it was not a part of the bill, then maybe he should not be paid.

Mr. ENNES. You put your fingers, Mr. Chairman, on the issue, and that is defining what those procedures are.

I should have made it clearer that the Health Insurance Association has had our committee on health education working with the hospital association, with the joint committee on accreditation, Blue Cross, and so on, together to get an agreement around what those criteria are.

We have felt that with the advent of the National Center, it probably is the best possible mechanism as sort of a neutral center to develop those criteria. If those criteria can be developed I think we can be assured that the paying mechanisms—and I hope that would include the medicare and medicaid as well—would come into the picture and we would have a solid national basis. This is an illustration.

Mr. Rogers. I hope so, too.

I was thinking the private industry should lead medicare and medicaid and show them how.

Mr. Ennes. The problem, Mr. Chairman, is the professional definition of what the care is, not the payment mechanism.

It is the definition, diagnosis, and treatment.

Mr. Rogers. You get care based on how you are paid. It may be a chicken and egg situation somewhat, but I am sure you are not going to get it if the payment mechanism——

Mr. Ennes. Exactly.

If we can get an agreement on what it is that we are paying we can provide the payment that will produce the result. We need an agreement in principle.

Mr. Rogers. Right, as to what should be done.

Mr. Ennes. We are prepared to do that.

Mr. Rogers. That is good and I think the committee probably will want to pursue that because I think until we really have some definite incentive, it is going to be very difficult to move the whole health system into the patient education area.

Mr. Ennes. Yes, sir.

Mr. Rogers. One other thing I wanted to ask you about is prevention. Most of the policies—I don't know that this is true, but I wanted to bring it to your attention—most of the policies cover diseases such as measles, if the individual has to go to the hospital, but most do not pay for the shot that could prevent the illness.

What action could be taken to encourage a payment mechanism that would encourage us to prevent diseases where we know how to prevent them, particularly in children and so forth?

Many may not have that particular coverage. I was not sure that most policies, or very many at all, have provisions for preventive care, which seems to me really would save the insurance companies in the long run, with some funds expended in the beginning for prevention.

Mr. Ennes. Mr. Chairman, we were aware of your interest in that matter. You made a speech referring to that I think a week or so ago.

Mr. Rogers. Yes.

Mr. Ennes. We made an informal survey among some of our member companies to determine practices. We didn't have a chance to do this on a very formal basis so I have sporadic sort of information. But I think I made the point earlier that over the years we have tried to meet the needs of our customers, and have been as flexible as possible in meeting those.

A little sidelight on that.

That is a part of the competitive marketplace situation, meeting needs of customers, and then the decision that customer makes is a very difficult one for us to override. And very frankly, there is an interesting relationship between sales and marketing and health education.

Mr. Rogers. I understand that.

Mr. Ennes. And we have some problems there, there is no question about it.

Some of our larger problems in the field of health insurance are convincing policyholders, employers, and workers to do what we are prepared to cover, but that they are not prepared to pay for. It is an interesting problem.

Mr. Rogers. But if all of the companies agree to pay for preventive care for children so that it would be a part of every health policy, it could probably save them in the long run from having to pay for the illness that the child may develop.

Mr. Ennes. As you recall, in our health insurance proposals, the National Health Care Act, H.R. 5990, we have a specification for child health care, well-child care, for benefit standardization for immunization for all children under five, and so on.

Mr. Rogers. This is the kind of thing we need to move to.

Mr. Ennes. We have done a little checking on our own situation. I can report to you that in terms of the kind of policies that my company writes—The Equitable—of those persons covered, roughly 92 percent are covered for immunization. This is a somewhat higher level than some of the other companies. We haven't been able to get that data but our people are covered with major medical and basic health services.

Mr. Rogers. So children could get——

Mr. Ennes. Absolutely could. The problem is getting them to use it.

Mr. Rogers. Yes, I am sure it is.

Mr. Ennes. That comes back to a health education problem. That is one of the reasons I am here.

Mr. Rogers. In your policies, 92 percent of your people are covered?

Mr. Ennes. Yes, sir.

Mr. Rogers. And they don't have to be ill to go——

Mr. Ennes. They do not have to be ill, do not have to pay a special bill.

Mr. Rogers. I wish more companies did that. We commend you for that.

I think it would be helpful if we could educate people to use the services for which they pay premiums.

Mr. Ennes. Exactly.

Mr. Rogers. I think some people now have urged that a health education benefit be included in national health insurance. I don't think it is in H.R. 5990——

Mr. Ennes. Not specifically, it is sort of basic to the whole thing.

Mr. Rogers. You think it would be appropriate?

Mr. Ennes. Oh, yes.

Mr. Rogers. And what would that be, and how should it be stated? Could you let us have some ideas on that for the record?

Mr. Ennes. Yes.

I don't think I could spell it out now because it is persuasive, and this is the point we have already made; we need something, and we have this National Center to develop exactly the basis for which that can be built. And we are aware, for example, of the priority in the Health Planning and Resources Development Act. We are very serious about that, and are moving in that direction.

Mr. ROGERS. What is the insurance industry doing now to make policies more understandable to the public? Are there any comparisons published between policies? Should there be, or not?

Mr. ENNES. This is a difficult area because so much of the private insurance as it is now written is to meet specific and individual needs of the policyholder. By and large, we are talking about large group policyholders. We have taken action to, first of all, simplify, to clarify and put in larger type our own policies at Equitable, and this is being done in most of the other companies, I think.

Also, through our Health Insurance Institute, the general informational service for the industry, as a whole, we have published just recently a consumer booklet providing basic information on the types and key provisions of health insurance policies, as well as guidelines for selecting coverage best suited to individual and family needs.

Mr. ROGERS. Would you mind furnishing the committee copies?

Mr. ENNES. I would be glad to.

Mr. ROGERS. I think it would be helpful to have.

[The following phamphlet was received for the record:]

WHAT YOU SHOULD KNOW ABOUT HEALTH INSURANCE

(By Health Insurance Institute, New York, N.Y.)

What is it going to cost if you, or someone dependent on you, needs medical care? More than you think, probably.

Health care costs have gone way up, and not just because of inflation, but because of better medical training, new treatments, scientific breakthroughs.

More illnesses are treatable and curable than ever before, but medical miracles are expensive.

The best advice for avoiding heavy family medical expenses is really very simple: stay well.

Good health practices can make that advice a reality most of the time. Ample rest, proper exercise, a balanced diet, regular physical check-ups, using good sense in smoking and drinking—these are some of the major ingredients of a healthy lifestyle.

Of course, these precautions, wise as they are, do not always work. Accidents and illness are a part of life. But here, too, good sense can prevail. Get medical attention promptly. Follow the doctor's prescription for recovery carefully. And make sure you have adequate health insurance protection to help pay the bills.

That brings us to what this booklet is all about—how to prepare yourself for the cost of illness or accident with health insurance provided by insurance companies.

Because individual needs vary so greatly, we can't tell you here specifically what health insurance policy to buy or exactly what kind of coverage you need. What we can do is give you some basic information to help you better understand the policy you may already have, and to see whether you need any additional protection.

WHAT HEALTH INSURANCE IS ALL ABOUT

Health insurance enables you to budget in advance for the unexpected and high cost of getting sick. All health insurance basically protects in one of two ways:

1. Against the costs of hospital, surgical and other medical care.
2. Against loss of income when a person cannot work due to illness or injury.

Chances are good that you already have health insurance. The fact is, some 186 million Americans are now protected by some form of coverage. It is offered by insurance companies, Blue Cross-Blue Shield plans, and other types of plans.

Most people have group health insurance, obtained through their employer, labor union, or perhaps a professional, fraternal, religious or alumni association. However, many millions have individual health insurance obtained through an agent or from an insurance company directly.

There are important differences between the types of health insurance. For example, if you are under a group plan where you work and leave your job, your coverage will end after a specified period. Many times, however, it is possible to convert the group coverage, without a physical exam, to an individual or family policy, though the premium cost will be higher. Alternatively, with the wide variety of policies available on a personal basis, one can purchase a plan that more adequately meets individual needs.

GROUP INSURANCE HAS CERTAIN ADVANTAGES

The employer or other group policyholder often pays part or all of the premium.

Premiums are lower because administrative costs are less when insuring a group of people under a single plan than when insuring people individually.

Persons are most times eligible at their place of employment for protection, regardless of their physical condition.

AN INDIVIDUAL POLICY ALSO HAS ADVANTAGES

The plan can be tailored to fit particular requirements, since everybody's needs vary to some extent. For example, if you're young, single, and in good health, your problems are different than if you're a family of five. People with individual or family policies are usually those who:

Feel they need to add to the protection they have under their group plan . . .

Are not covered by a group plan, or . . .

Want assurance of continued protection between jobs.

Individual policies come in three basic types. One is guaranteed renewable. This means that the policy stays in effect up to a certain age as long as the premium is paid promptly. The premium rate cannot be raised for any one individual, only for all policyholders in the same class such as those in one particular state.

Another type policy is non-cancellable, meaning the company can't cancel or raise the premium. This is available only in insurance that protects you against loss of income.

Understandably, the least expensive health insurance policies are those where the insurance company—along with the policyholder—has the option to renew the policy or not each year. These are known as optionally renewable policies.

A LOOK AT "BASIC PROTECTION"

We call insurance against the costs of ordinary hospital care, surgery and doctor's services—"Basic Protection."

"Basic Protection" benefits for care in the hospital cover you for periods ranging from 30 to 365 days or longer, depending on the particular policy.

In general, these benefits help pay for two types of services:

1. Daily room and board in the hospital, routine nursing care and minor medical supplies.

2. Other hospital services, such as laboratory tests and X-rays, anesthesia and its administration, use of operating room, drugs and medications, and local ambulance service. In your policy these services may be referred to as miscellaneous or ancillary expenses.

Frequently the benefit for these additional services is expressed as being so many times the room and board benefit. For example, if the room and board benefit is $50 a day, the additional expense benefit may be 10 times this amount, or $500.

As for maternity care, these policies frequently provide a single lump sum payment toward hospital costs of a normal birth. This, too, is commonly expressed as so many times the hospital room and board benefit. More and more, however, in a group plan, maternity costs are treated as other non-maternity and medical costs. Usually the benefit payment is larger for Caesarian section, and smaller for an abortion.

Also available are cash benefit policies which provide money to help meet additional expenses during an illness. Usually these benefits are paid only for the time you're in the hospital; they are known as hospital indemnity policies.

There are specific things you'll want to know about your hospital coverage:

How many days of hospital care does it cover?

How much does it pay for each day?

How do these hospital benefits compare with charges in your hospital? (Ask your nearby hospital what its daily charges are.)

Surgical expense benefits help pay the cost of operations. These benefits can apply even to minor operations in the doctor's office.

Your "Basic Protection" policy probably contains a list of common surgical operations and the maximum benefit that can be paid for each.

Do keep in mind that physician fees vary, so you'll want a policy in line with what doctors are charging in your community. (Discuss fees with your doctor.)

There are also benefits for treatment by a doctor that does not involve surgery. Commonly, this helps pay for a certain number of visits in the hospital. Some policies also provide benefits for home and office visits.

Check your policy to see how much it pays for each time your doctor visits you in the hospital.

Other things to look for:

How many doctor visits in the hospital are allowed?

Are you covered for house calls and office visits?

MAJOR MEDICAL EXPENSE INSURANCE

If you have this type of policy, you have protection against the bills that result from serious and prolonged illness. The amount a Major Medical policy pays depends on the plan you have.

Some pay up to $20,000; some up to $250,000; some have no limit at all. A high-benefit policy is popularly known as "catastrophic coverage."

One thing is certain: in these days of high health costs, every individual and family, regardless of income, needs the kind of protection only Major Medical benefits can assure. These plans can be purchased independently or to supplement your "Basic Protection."

These benefits help pay for virtually every type of care and treatment prescribed by a physician, both in and out of the hospital, including:

Hospital services

Physician's treatment and specialist's consultation and care

Surgery

X-ray and laboratory services

Anesthesia and its administration

Private duty nursing

Prescribed drugs and medicines

Major Medical insurance has a deductible amount which is paid by you or by your "Basic Protection" insurance before Major Medical benefits start. This can range from $50 to $1,000 or more, depending on the policy. The higher the deductible, the less the policy usually costs.

As a rule, Major Medical policies also have a co-insurance clause. This means the insurance company pays 75 to 80 per cent of the expense left after you pay the deductible amount. However, many of the newer "catastrophic" plans now say that once you've paid a certain amount, typically $1,000, the insurance company will pay the rest, up to the benefit limit. Of course, this would go only toward expenses you're insured against.

Many families have Major Medical insurance to supplement their "Basic Protection." Other families have their Basic and Major Medical protection combined into a single policy, called Comprehensive Major Medical Insurance.

Here are important things you should know about any Major Medical plan you select.

MAXIMUM BENEFITS

How much is the maximum benefit (or is it unlimited)?

Can the maximum benefit be restored after it has been partially or fully used up—if so, how?

Is there a separate maximum benefit for each illness or accident? Or a yearly maximum benefit for all illnesses or accidents?

DEDUCTIBLES

How much is the deductible amount?

Is it a yearly deductible amount? Or is it a deductible amount for each illness?

Is there a time limit for reaching the deductible amount?

CO-INSURANCE

What percentage of expenses do you pay?

Is there a cut-off point for co-insurance—or is co-insurance reduced as your expenses go up?

INTERNAL LIMITS

Are there benefit limits on certain expenses, such as the hospital room or surgery?

WAIVER OF PREMIUM

Does the policy allow you to stop paying your premium during an illness?

DURATION OF POLICY

Does your policy end at age 65, or continue for your lifetime?

DISABILITY INCOME INSURANCE

What about your income if you're laid up? This has to be considered as one of the costs of getting sick. Some employers continue paying salaries during temporary absences from the job because of accident or illness. However, there usually are time limits beyond which full pay is reduced or eliminated.

Disability Income Insurance (also called loss of income insurance) helps replace these earnings lost because of disability.

Benefits during disability are limited to some part of regular income, such as 50 to 60 per cent of a person's gross earnings. For example, if a wage earner's pay is $200 a week, benefits might up to $120 weekly.

These policies generally require that a person be totally disabled before benefits are paid. Some policies provide benefits if an individual is partially disabled, usually following a total disability.

How is total disability defined? Your policy may have one or a combination of both of the following definitions:

Unable to perform the duties of your occupation.

Unable to engage in any gainful occupation for which you are suited by education, training or experience.

Policies may have waiting periods before benefits begin—commonly 14, 30 or 90 days. The longer the waiting period, the lower the premium cost will be.

But many policies do provide benefits starting on the first day of an accident and the eighth day of an illness.

Benefit periods for individual Disability Income Insurance policies can range from one year to age 65 or even for life, depending on the contract. The longer the benefit period, the higher the premium cost.

In figuring out your needs for Disability Insurance, be sure to take into account how long your employer will continue paying your salary if you're unable to work. Also, how long any other income will continue, such as Social Security disability and, in a few states, state disability plan payments.[1] This will enable you to calculate the right waiting period for your needs—and will help you to better budget against loss of income. In other words, the right policy for you at the lowest cost.

SOME OTHER THINGS TO LOOK FOR

Besides the limitations in health insurance already discussed, policies also have *exclusions*—conditions that are not covered. For example, one condition would be an illness you have at the time you purchase an individual policy (in other words, a pre-existing condition).

Policies may exclude injuries from war or those that are self-inflicted. Some will help pay for mental illness under certain conditions, but may exclude long stays in mental hospitals. There is always a waiting period before maternity is covered and some policies, usually ones for individuals, exclude maternity coverage altogether except for any serious complications.

In most cases, people with physical disabilities can obtain an individual policy, though it may cost more.

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[1] New York, New Jersey, California, Rhode Island, and Hawaii.

OTHER ELEMENTS OF PROTECTION—IF YOU QUALIFY

If you're injured at work, you are eligible for Worker's Compensation. Social Security will pay you cash benefits after five months if you become totally disabled by sickness or accident and it looks as though your disability will last 12 months or longer.

If you're 65 or over, you are probably covered by Medicare. (Medicare can also cover disabled people under age 65.) Medicare will help pay your hospital bills and a portion of your medical costs.

Many senior citizens worry about hospital and medical costs which aren't covered or go beyond what Medicare will pay for. Senior Major Medical policies are available to supplement Medicare benefits.

If your income is below a certain level, you may be eligible for Medicaid, a federal-state program that can help pay your health care costs.

So talk to your local Social Security office about Medicare. To find out about Medicaid, talk to your local welfare department.

A FEW FINAL THOUGHTS

Here are the four main points to remember when planning your health insurance program:

1. Determine as precisely as you can what your health insurance needs are and make sure your coverage fits these needs. Pay special attention to "catastrophic coverage"—that is, a high-benefit Major Medical policy—and protection against loss of income.
2. Know exactly what your insurance will pay for and what it won't.
3. Periodically review your insurance to make sure it is in step with your family's current situation as well as today's costs of care.
4. Finally, compare policies. It's possible to save money on the kind of coverage you need—just be sure you understand what you're buying.

If you have questions about a group plan, you should be able to get the answers from your employer, union or association officer.

If your question is about an individual or family policy, talk it over with your inisurance agent or contact the insurance company directly.

Mr. Rogers. Dr. Carter?

Mr. Carter. Thank you.

I want to commend you on your statement here today. Actually, my view of education may be a little bit different perhaps than those of some others.

I want to congratulate you first on the formation of your center. I believe you are involved in the private sector; is that not right? It seems to me that your function is to educate people as you can, using what methods are possible; television, for instance, and school visitations; through the different associations of groups of citizens which groups have been formed for a definite purpose, such as diabetes or arthritis; and, again, through health officers and nurses.

I think that such education might include warning about other health dangers: For instance, the danger of smoking, the danger of certain foods, obesity, and so on, malnutrition, and lack of exercise. It seems to me this is an area that we should aim at. And in keeping people healthy, of course, immunization, as I see it, certainly is a part of this.

I regret that our immunization levels for our children have declined percentagewise. I am concerned our public health system—throughout our country is really not what it was at one time.

At one time we had many public health officers throughout the United States, and in some States practically one in every county, with adequate nursing services. There were school visitations at which the children were immunized. Not only preschool chiidren were given examinations before they went to school—but also prenatal services for poor mothers were provided. Unfortunately, we have diminished our efforts in these areas.

Because of financial problems, we have not had sufficient funds in our country to hire these public health officers we once had. The physicians can make more money in private practice and, therefore, they choose that, as I see it.

But one thing that has struck me as particularly strange is the fact that it is alleged that some of our physicians do not practice health education, or do not educate their patients. To me, that is preposterous. There may be some who don't, but the first thing that a physician does when a patient comes into his office, if he is worthy and well-qualified, is to get a history of that patient. Next, he makes a physical examination. Then he does whatever laboratory work and X-ray work as is necessary. After this, he arrives at a diagnosis, whether it be correct or not—I hope it would be correct—and then he prescribes. He has a treatment for that patient, and as I have seen, most of the physicians are very careful in educating the patient as to what the patient should do.

For instance, if he is a diabetic he is always given a diet list and informed of the amount of insulin which he should take. He has to be observed for several days to be sure that the number units is exactly correct. Of course, he is given instructions on how to sterilize his syringe. He is told where to get plastics that we now commonly use, which are already sterilized. He is instructed how to attempt to sterilize the arm or the portion of the body where the injection is given, and is told about the dangers of too much or too little insulin, and possibly of coma, and so on.

So the charge that physicians don't practice health education is really an indictment of the medical profession. I think it is unwarranted and personally, I hope to see the education in the ways that I have mentioned continued, keeping our youngsters well by preventive medicine and immunication, and so on.

If he is a good physician, and I trust I hope most of them are, he is going to do the things which I mentioned.

Do you agree or disagree with what I have said?

Mr. ENNES. It is a rather long statement to agree or disagree in all details. I don't think there is any question that the physician has an educational impact on the patient.

My argument is that very frequently that is a very negative impact, and the problem is that we have expected the physician, in an extremely limited amount of time and with virtually no preparation in matters of communication with his patients, to do a superb job. We expect this of our physicians.

That is rather unfair, I think. I think we need to look at the problem in a totality and develop some ways of making it possible for the physician, man or woman physician, to do the kind of job you are visualizing.

I think this is what we have to aim for, and I am interested in your original, earlier comments about the developments in the public health field. I am an old public health man, and it is fascinating to me to look back over the history of public health in this country and to see that the diversion of concern on the part of the public health authorities and public health officers into "medical care" which has really a very important but relatively minor impact on the health status of the people of this country, and we have systematically dissipated the public health system in this country.

Mr. Carter. Absolutely.

Mr. Ennes. Now we are saying we have to go back to what we talked about then: environmental issues, community relations issues, communication problems, educational problems—if you will, the entire relationship of the community, its members, to their feelings of effectiveness and productivity, and so on. I think it is an interesting historical switch. I think we are ready now to get back to work on the whole situation.

Mr. Carter. Well, as I see it, we have to go back on many things. We see that we have planned very, very poorly. We ripped up our streetcar tracks——

Mr. Ennes. And railroads.

Mr. Carter [continuing]. Mass transportation. Then we have bumper to bumper traffic coming into our towns, cars spewing either hydrocarbons, carbon monoxide particularly, or sulfuric acid. We brought this on ourselves. It was a lack of planning and lack of good sense and good judgment years ago, and we have done the same thing I am afraid in the health field.

Thank you, Mr. Chairman.

Mr. Rogers. Thank you so much, Mr. Ennes, for being here.

Our next witness is the vice president of the Blue Cross Association, Communications, Mr. Duane R. Carlson.

Mr. Carlson, we welcome you and appreciate your presence and your statement will be made a part of the record in full [see p. 394].

STATEMENT OF DUANE R. CARLSON, VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. Carlson. I would like to give it a very brief summary.

We appreciate the opportunity to comment on the subject of health education because significantly, the three bills before this Committee recognize what may readily become a turning point in national health policy—the awakening understanding that the goals of better health must be sought not only through improved access, financing and control of our services for the acutely ill and injured, but also through sustained, systematic programs aimed at persuading and motivating the people themselves to accept responsibility for their own health, and giving them the information and incentives they need to keep well.

The time is right for new initiatives in health education of the public. In the health field, as in other fields, we see evidence of a shift from a technocratic, materialistic orientation toward a total view of man and his environment, with the quality of life being accepted as the final measure of value. As part of this change, an increasing emphasis is being placed on the true determinants of health and on preventing illness, rather than continuing a narrow focus on curative interventions once the individual has become ill.

The track record in health education and promotion shows how many challenges we face in informing and motivating people to change their behavior and the circumstances of their lives in ways which will safeguard and improve health and enrich, if not prolong, life. Health information as it is too often presently conducted is fragmented, not adequately based on analyses of what consumers either need or want to learn, presented without the opportunity to translate theory and data into practical applications, presented in unimaginative or unnecessarily technical style, inadequtely related to lifestyle and often in conflict with other messages. However well intentioned, many of these activities are an exercise in futility.

It is hard to overstate the significance of this inadequacy in our system, or chain, of health services.

While the general thrust of the three bills before the committee would help meet the challenges I have outlined, we have concern with regard to the following specific matters:

The first is having private sector involvement.

Here, I would like to ask your permission, Mr. Chairman. There was a reference omitted in the preparation of the testimony, because we do feel that the National Health Council and their work under a contract with the Center for Disease Control has developed a plan which led to the establishment this fall of such a private center, the National Center for Health Education, which is functioning and is charged with promoting, coordinating and upgrading programs in health education, and we feel that this organization could fulfill this private sector role.

Mr. ROGERS. Thank you.

That will be included in your statement.

Mr. CARLSON. Thank you.

The giving of a major role to the Center, which would work in coordination with the Institute, would help assure the achievement of the type of innovative projects and research needed to stimulate the development and implementation of effective health education programs. In their work together, the Center and the Institute should share regular reports on their programs and progress with the American people.

Health information—our concern here relates to health "information" as compared with health "education." In a number of instances, the bills urge the gathering and dissemination of health information to the general public.

As an example, section 1713(a)(4) of H.R. 8278 deals with the provision of toll-free telephone systems. Section 1714 deals with a variety of information programs including pamphlets, reports, and a journal for the general public. As a general matter, the overriding need is not for the provision of more information; rather, the need is to change individual behavior that adversely affects health.

Rather than concentrating too heavily on implementation, we should focus now on research and demonstrations, allocating resources to reflect the needed emphasis.

All three of the bills would establish a national advisory council. To the list of proposed members, I would add health insurance carriers to reflect the involvement and commitment of this segment of the health care delivery system.

For one, the Blue Cross Association has adopted a white paper on patient health education which encourages health institutions to establish and operate programs of health education, supported financially through the existing payment mechanism.

Also, BCA and the Blue Cross plans have been active in a variety of health education programs and activities, accepting this as one of their community responsibilities.

Mr. Rogers. Would you furnish the committee with a copy of the white paper?

Mr. Carlson. Yes; we will be glad to, and will do so [see p. 397].

Mr. Rogers. Thank you.

Mr. Carlson. Also, in line with our comments regarding the new talent, ideas, and approaches needed in this field, I would not restrict the educational field's involvement in the Council to "health educators," but would include those in the general educational area who could contribute to fulfillment of the bill's goals.

To sum up, the challenge facing us is first to understand the broad elements involved in health education and promotion and then to act. Given the range of ideas, we would put a high premium on flexibility and view orthodoxy with high skepticism.

What is needed most now is the ability to establish broad goals, to translate them into practical, achievable steps, and to coordinate the existing programs and bits of pieces of programs while initiating the new programs that would fill in the gaps and sustain movement toward the goals. This is the stuff out of which effective change takes place.

If we consider the ultimate goal to be to safeguard and improve health and enrich life, then the things people do—or don't do—for themselves take on considerable meaning.

The ultimate job to be done cannot be accomplished until and unless society as a whole comes to consider health as important as healing. And that is a job for health education of the public, a vital job which your comhmittee's deliberations can help accomplish.

[Mr. Carlson's prepared statement and white paper follows:]

Statement of Duane R. Carlson, Vice President, Blue Cross Association

I appreciate the opportunity to comment on the subject of health education. Significantly, the three bills before this Committee recognize what may readily become a turning point in national health policy—the awakening understanding that the goals of better health must be sought not only through improved access, financing and control of our services for the acutely ill and injured but also through sustained, systematic programs aimed at persuading and motivating the public themselves to accept responsibility for their own health, and giving them the information and incentives they need to keep well.

While the imminence of some form of national health insurance has certainly been one reason for the rising interest in health education, the fact that economic conditions may postpone the effective date of any such insurance program does not by any means diminish the urgency of the need for more effective health education. Instead, it provides a little more time for organizing the resources, expanding the programs, and initiating the research that must be conducted as essential components of any national health insurance strategy. The improved access, financing, and controls that can be achieved through a financing program will still fall short of reaching the goal of improved health status of the population unless these are accompanied and supported by activities of the type envisioned in the proposed legislation.

In fact, the need for health education as a means of rationalizing demand for and use of services is so essential to the stability and success of national health insurance that it should be included or referenced in the health insurance legislation itself.

The time is right for new initiatives in health education of the public. In the health field, as in other fields, we see evidence of a shift from a technocratic, materialistic orientation toward a total view of man and his environment, with the quality of life being accepted as the final measure of value. As part of this change, an increasing emphasis is being placed on the true determinants of health and on preventing illness, rather than continuing a narrow focus on curative interventions once the individual has become ill.

While health education needs to concern itself with such matters as reasonable intelligence and knowledge about the early signs of diseases and the social psychological-emotional adaptation of the patient to the realities of his disease, if it is to be effective it must take into account the areas of practice or knowledge that appear to be health promoting. For example, more emphasis should be placed on efforts to promote sensible diet and less use of food as a source of gratification, reasonable physical activity, protection from dangers in the physical environment, prudent use of mood-altering agents, etc.

The track record in health education and promotion shows how many challenges we face in informing and motivating people to change their behavior and the circumstances of their lives in ways which will safeguard and improve health and enrich, if not prolong, life. Health information as it is too often presently conducted is fragmented, not adequately based on analyses of what consumers either need or want to learn, presented without the opportunity to translate theory and data into practical applications, presented in unimaginative or unnecessarily technical style, inadequately related to life style and often in conflict with other messages. However well-intentioned, many of these activities are an exercise in futility, whether the sponsoring group is a health institution or voluntary association, an employer, union, insurer, or public health agency.

It is hard to overstate the significance of this inadequacy in our system, or chain, of health services. No one can know just how much of the $110 billion aggregate cost of health services might have been saved last year by more emphasis on effective health education programs. At any level, however, it is less important that the lives that could be saved and those that would be enriched by freedom from suffering and anxiety caused by accidents, alcoholism, obesity, drugs, and invalidism due to preventable disease.

While the general thrust of the three bills before the Committee would help meet the challenges I have outlined, I have concern with regard to the following specific matters:

1. *Establishment of a Government Agency.*—H.R. 8278 would authorize the establishment of a National Institute for Health Information, Education, and Promotion; H.R. 5839 would establish a National Center for Health Education and Promotion; H.R. 3205 would establish a Health Education Administration. My main concern here is with the centering of health education and research activities in an agency of the government. While we need to find effective means to stimulate innovation in health education—a field rife with individual sensitivities—it is our experience that operating agencies of the federal government generally pursue low-risk courses, are reluctant to initiate programs which might be thought to border on religious sensitivities and are hesitant to invade areas that are considered to be within the jurisdiction of the states. Because the nature of health education programs invite these complications, the Institute, as conceived in H.R. 8278, for example, might be disinclined to engage in essential innovation and demonstration projects. For instance, while it is generally recognized that behavior modification is a key goal of effective health promotion strategies, a government agency may fear running the risk of raising the spectre of "big brother" by initiating and carrying out experiments in this area.

The report of the President's Committee on Health Education envisaged Congressional authorization of a private, nonprofit Health Education Center to be funded by both the federal government and private sources. Such a private Center, in my judgment, would be better suited than a governmental agency to stimulate and encourage health education, to help move the nation into action, and to monitor, evaluate, and communicate with regard to the multiple efforts which are undertaken. As Vice Chairman of the Committee, I strongly supported this recommendation.

The National Health Council, under a contract with the Center for Disease Control, developed a plan which led to the establishment this fall of such a private center, the National Center for Health Education. The Center is charged with promoting, coordinating and upgrading programs in health education.

This organization could fulfill the role proposed in the President's Committee report.

The giving of a major role to the Center, which would work in coordination with the Institute, would help assure the achievement of the type of innovative projects and research needed to stimulate the development and implementation of effective health education programs. In their work together, the Center and the Institute should share regular reports on their programs and progress with the American people.

While the government has already established a coordinating center for health education activities in the Department of Health, Education, and Welfare, the new Bureau of Health Education has been based in the HEW Center for Disease Control in Atlanta. This is somewhat removed from the scene of action—in the Office of the Assistant Secretary for Health—and this possibly could serve to be more of a brake than a stimulus to the kind of innovative thinking that is called for.

Nevertheless, the bureau is in business and we applaud the government's action in establishing this focal point for federal initiatives in health education. In this coordinating role, the bureau can work to assure that all government agencies involved in some form of health education—such as the Labor Department, the Veteran's Administration, etc.—coordinate their efforts to gain maximum impact from the funds and talent committed to their projects.

2. *Health "Information."*—My concern here relates to health "information" as compared with health "education." In a number of instances, the bills urge the gathering and dissemination of health information to the general public. As an example, Sec. 1713(a)(4) of H.R. 8278 deals with the provision of toll-free telephone systems; Sec. 1714 deals with a variety of information programs including pamphlets, reports, and a journal for the general public. As a general matter, the overriding need is not for the provision of more information; rather, the need is to change individual behavior that adversely affects health. The bill recognizes the need for the application and use of health knowledge (Sec. 1701(3)(B)) and for programs to determine and study environmental, occupational, social and behavioral factors which affect and determine health (Sec. 1712(a)(6)), but provides insufficient checks against pursuit of the easier road of information within limited budgets.

In addition, we must admit that the state-of-the-arts in health education is not great. In such a setting, the wholesale implementation of inchoate programs, under Medicaid or any other program, could be counterproductive, resulting in a sharp increase in the volume of information while ignoring the need for certain basic advances. Rather than concentrating too heavily on implementation, we should focus now on research and demonstrations, allocating resources to reflect the needed emphasis.

3. *Assessment of Health Impact.*—One aspect of the information program of H.R. 8278 is an assessment of "new aspects of health care" (Sec. 1714(B)). As a general matter, I would urge that assessment activities involving basic research be undertaken in a separate agency, not the one charged with the dissemination of information and the motivation of behavior changes. Such assessment requires an extensive and costly scientific capability such as presently exists in a number of agencies (NIH, FDA, etc.) and thus there is no need to replicate these existing facilities. Assessment of operating programs, on the other hand, should be part of the Institute. Regular assessments of research and operations are needed and the findings—shared with the Center and the Institute—will help them focus on the most effective courses of action.

"False or misleading advertising" is addressed in Sec. 1714(2) of H.R. 8278, with the basic purpose of reducing the possible negative effect which specific advertisements may be found to have on the health of the population. However, the wording of this section is so open-ended that it could lead to a dissipation of staff energies through a lack of agreement as to the proper focus of these activities and to considerable confusion and perhaps undeserved criticism on the part of advertisers and their agencies.

In a lesser vein, I should like to offer several additional observations with particular reference to H.R. 8278. Sec. 1713(b)(2)(B) outlines several requirements for health education centers. The intent is to assist promising private demonstrations, research, and evaluation in the general area of health education. This would be accomplished by the establishment of at least ten centers located in "an established academic or research institution." I caution against such a restriction as to the setting, particularly with regard to demonstration programs.

It may be preferable to undertake demonstrations in a variety of settings, including operational as well as academic and research entities. Another requirement is for a full-time director "who possesses a demonstrated capacity for sustained productivity and leadership in the field. . ." While I agree as to the need for a "demonstrated capacity," I caution against a strict interpretation of this requirement as "fully credentialled in health education." The field needs to attract new talent and new ideas and approaches; the requirements for the Center should not be restrictive in this regard.

Medicaid sanctions are proposed in H.R. 8278 to motivate states and institutional providers to conduct certain programs and activities (Sec. 1703(b)(1)(A), Sec. 1703(c)(1)(A)). Again, I urge caution in widespread implementation of largely informational programs. However, in implementation, albeit gradual, incentives should be employed as well as sanctions; Medicare and other programs should be used as well as Medicaid.

All there of the bills would establish a national advisory council. To the list of proposed members I would add health insurance carriers to reflect the involvement and commitment of this segment of the health care delivery system. For one, the Blue Cross Association has adopted a white paper on patient health education which encourages health institutions to establish and operate programs of health education, supported financially through the existing payment mechanism. Also, BCA and the Blue Cross Plans have been active in a variety of health education programs and activities, accepting this as one of their community responsibilities. Also, in line with our comments regarding the new talent, ideas and approaches needed in this field. I would not restrict the educational field's involvement in the Council to "health educators," but would include those in the general educational area who could contribute to fulfillment of the bill's goals.

To sum up, the challenge facing us is first to understand the broad elements involved in health education and promotion and then to act. Given the range of ideas, we should put a high premium on flexibility and view orthodoxy with high skepticism.

What is needed most now is the ability to establish broad goals, to translate them into practical, achievable steps, and to coordinate the existing programs and bits of pieces of programs while initiating the new programs that would fill in the gaps and sustain movement toward the goals. This is the stuff out of which effective change takes place.

If we consider the ultimate goal to be to safeguard and improve health and enrich life, then the things people do—or don't do—for themselves take on considerable meaning. The ultimate job to be done cannot be accomplished until and unless society as a whole comes to consider health as important as healing. And that is a job for health education of the public, a vital job which your Committee's deliberations can help accomplish.

White Paper: Patient Health Education

> The following White Paper addresses the issue of patient health education and the operational role which Blue Cross Plans can assume in this area. It finds that a patient education program, integrated into the routine services of the institution, offers the potential for both cost containment and improved quality of patient care. It concludes with the recommendtaion that Blue Cross Plans should encourage health care institutions to establish and operate programs in patient education and should support them financially through the existing payment mechanism.

The health care system is being challenged to improve its efficiency and effectiveness. Reforms in the system must forcefully address the need to contain rising health care costs and to assure the quality of health care services.

Given the complexity and the diversity of this challenge, no single response is appropriate. As one mechanism among many, patient health education may contribute to containing health care costs and enhancing the individual's understanding of and compliance with this treatment regimen. Patient education reinforces the patient's awareness of his responsibiilty for his own health, and self-responsibility is crucial for the ultimate effectiveness of health care.

Patient health education, for the present purpose, is a process comprising several elements: mutual identification of present and future health care needs by patient and professional, planning for the appropriate mix of professional and patient responsibility for meeting those needs, exchange of knowledge regarding the selected treatment regimen, motivation of patient and professional to perform their respective roles, and continuing evaluation of alternative methodologies. Patient education is part of the total process of patient care. As used here, patient education generally refers to hospital-based programs. However, the locus of the intervention is not as important as its nature.

The purpose of this statement is twofold: to examine the evidence on the impact of patient health education on the cost and quality of patient care and to recommend an operational course of action to Plans.

Issues

The concept of patient health education raises several issues. The principal questions which must be resolved, however, are:

1. Should Plans pay for patient education?
2. What kinds of criteria should be employed to determine the allocability of patient education expenses to Plan reimbursement?
3. What is the appropriate role for Plans in patient health education?

The answers to such questions emerge from an evaluation of the impact of patient education on the cost and quality of health care.

Effects on costs

In examining the costs of patient care, one may adopt several perspectives: health care costs per capita in a given service area, costs per admission, costs per service unit, and costs per episode of illness. The development of valid and reliable measures is crucial to the proper evaluation of the patient education program.

Theoretically, patient education might contribute to reduced costs by decreasing the unnecessary utilization of health care services and by encouraging use of the most appropriate focus of care for health problems. These potential effects are critical to improving the efficacy of medical services.

Empirical evidence suggests that structured patient education speeds recovery in certain case types. For example, preoperative instruction has resulted in a significantly higher incidence of early discharge among those receiving intensive preoperative instruction and practice as compared to those not receiving such treatment.[1] Other studies have found similar results. Specific educational interventions can lead to reduced use of post-operative narcotics,[2] decreased emergency room utilization,[3] decreased readmissions and patient days for readmissions,[4] and reduced total admissions for a target population.[5]

Total health care cost for the individual may be reduced by substituting less expensive treatment modalities and loci of care for hospitalization and emergency room use. To asess whether such substitutions really do reduce total costs, total utilization of health services by specific groups over a given time frame must be calculated.

While not presenting conclusive evidence of reduced total costs of care for specific groups, some studies do suggest large cost savings as a result of changes in the pattern of utilization. For example, the Tufts-New England Medical Center research,[6] using a self-selected sample of male hemophiliac outpatients given postperiod instruction and practice in self-infusion, yielded the following pre-post comparisons: total inpatient days declined from 432 to 42, outpatient visits per patient decreased from 23.0 to 5.5, and total costs per patient went down 45% (from $5,780 to $3,209). At the University of Southern California Medical Center, a reorganization of the diabetic care system, incorporating a telephone "hotline" for information, medical advice, and the filling of prescriptions, counseling by physicians and nurses, and pamphlets and posters to promote the service, was associated with more than a 50% reduction in emergency room visits per clinic patient and the avoidance of approximately 2,300 medication visits.[7] These findings suggest that certain types of patient education do promote the substitution of self-care and information-seeking for acute care services.

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[1] Healy, Kathryn M., "Does Preoperative Instruction Really Make a Difference?" American Journal of Nursing, January 1968, pp. 62–67.

[2] Egbert, Lawrence D., et al., "Reduction of Postoperative Pain by Encouragement and Instruction of Patients," New England Journal of Medicine, April 16, 1964, pp. 825–827.

[3] Miller, Leona, and Goldstein, Jack, "More Efficient Care of Diabetic Patients in a County Hospital Setting," New England Journal of Medicine, June 29, 1972, pp. 1388–1391.

[4] Rosenberg, Stanley G., "Patient Education Leads to Better Care for Heart Patients," HSMHA Health Services Reports, September 1971, pp. 793–802.

[5] Ibid.

[6] Levine, Peter H., and Britten, Anthony F., "Supervised Patient Management of Hemophilia," Annals of Internal Medicine, No. 78, 1973, pp. 195–201.

On balance, organized patient education has demonstrated its effectiveness in reducing the unnecessary utilization of certain health care services and in encouraging the use of the most appropriate, least-cost settings for care.

Effects on quality of care

Patient health education has also demonstrated considerable potential for improving the quality of care.

Several studies have demonstrated the beneficial impact of patient education on the process of patient care. The use of an interdisciplinary team to provide educationally oriented support to patients with congestive heart failure has resulted in increased knowledge among study patients in one sample regarding diet, medications, disease process, and, even more importantly, increased adherence to the treatment regiment.[8] Other research suggests that patient education enhances patient understanding of and compliance with the process of care.[9]

With respect to health care outcomes, studies have shown the quality-increasing effects of patient education. At the University of Southern California Medical Center, the reorganization of the system of diabetic care and the initiation of a multi-faceted program of patient education was associated with a reduction of approximately two-thirds in the incidence of diabetic coma from 1968 to 1970.[10] Similarly, in another study, a significantly higher percentage of congestive heart failure patients receiving educational support improved in their ability to function, as measured by the American Heart Association classification. Also, recent work [11] at Massachusetts General Hospital has shown that the provision of intensive preoperative and postoperative information and guidance contributed to reduced pain among surgery patients. These studies point to the potential of patient education in enhancing health status.

Conclusion

The available information regarding patient health education indicates that, where conducted by a coordinated mix of educational and clinical specialists and directed to individual needs and capabilities, it both increases the quality of health care and presents potential cost savings to the health care system and to the public it serves. The Blue Cross system has consistently supported delivery and financing innovations which improve the system's efficiency and effectiveness. As such, patient health education efforts should be encouraged and supported, for they are one promising means of achieving these objectives.

Accordingly, Plans should encourage health care institutions to establish and operate programs in patient education and should support them financially through the existing payment mechanism. To realize its full potential for cost savings and quality improvement, it is critical that the patient education function be integrated into the total process of patient care. To assure that sound programs are developed and maintained, the following guidelines are suggested as criteria for determining payment for patient education programs. In applying these guidelines, the variation in programs and population needs for patient education should be considered. Accordingly, a flexible approach to their interpretation should be adopted.

Guidelines for programs in patient education

1. The purpose and operational objectives of the program should be clearly stated, and the techniques for meeting the objectives should be specified.
2. Patient education should be provided as an integral element of the total patient care process within a supportive organizational framework.[12] Existing hospital-based programs in patient education shall be reviewed by either the Joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association.

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[7] See previous study by Leona Miller and Jack Goldstein.

[8] Rosenberg, Stanley G., "Patient Education Leads to Better Care for Heart Patients."

[9] Reported in: Green, Lawrence W., "Toward Cost-Benefit Evaluations of Health Education: Some Concepts, Methods, and Examples," pp. 36–37 (unpublished paper).

[10] Miller and Goldstein.

[11] Egbert, et al.

[12] Examples of this organizational framework are the hospital, home care program, HMO, or community health education program.

3. Necessary and appropriate health education should be developed and financed as a routine element of the care of each patient.

4. Educational methodologies should be directed to specific case types and desired behavioral changes and the results of such interventions as to cost and quality of care should be documented. As in other expenses, continuing management evaluation of the cost effectiveness of the service should be conducted. Programs should be revised over time to reflect the results of such evaluation.

It is appropriate that the Blue Cross system encourage the development of cost-effective programs in patient education. Where patient education is properly related to the other components of the total patient care process, there is clear potential for reduction of health care costs and improvement in the quality of health care processes and outcomes. Blue Cross Plans share responsibility with those providing patient education to ensure that this potential is realized. Accordingly, the Blue Cross System should play an active part in the development, implementation, and evaluation of sound programs in patient education.

Mr. Rogers. Thank you very much, Mr. Carlson.

Does Blue Cross cover health education?

Mr. Carlson. Yes. Right now it is paid for primarily through the normal reimbursement mechanism in the hospital in that when the dietitian is counseling the diabetic on diet, for instance, that would be covered under the regular payment.

However, under the concept of our white paper, our policy statement—we would single out and specifically pay for interventions such as that, as well as other new initiatives. We are doing so now in Montana, and some other plans.

Mr. Rogers. You are trying it in some areas?

Mr. Carlson. We feel it must be encouraged, and that was the purpose of the white paper.

Mr. Rogers. Thank you.

You are going to give us a copy of that?

Mr. Carlson. I shall.

Mr. Rogers. What about Blue Cross, do you cover immunization or must the person be sick?

Mr. Carlson. Under certain of our contracts, we do pay for immunization. This is both done under Blue Shield coverages, such as well baby care, as well as our outpatient programs. However, we have found that one of the biggest problems is motivation, and this is why we do a significant amount of public service advertising, aimed at trying to motivate people to take advantage——

Mr. Rogers. I noticed some of your advertising, which I commend you for, it is very good—I noticed it on TV.

Mr. Carlson. Thank you.

Mr. Rogers. For instance, the Federal employees group here, do you cover immunizations?

Mr. Carlson. I am not sure if it is specifically singled out. It may well be under the outpatient. I could find that out and provide that.

Mr. Rogers. It is my understanding that you do not if the person is well.

Mr. Carlson. I am sorry, I am not certain about this.

Mr. Rogers. If you would let us know your policy on this it would be helpful.

Mr. Carlson. Certainly.

Mr. Rogers. Your suggestions are good and I commend you for the fact that you really do support health education, and find that it would be a very important factor in improving the health of our people.

Mr. Carlson. Indeed.

Mr. Rogers. Dr. Carter.

Mr. Carter. Thank you, Mr. Chairman.

You say that you do pay dietitians if they advise patients?

Mr. Carlson. Normally, there has been a lot of what would be considered patient education done that is not singled out, or is cited on someone's bill, when paying for services in the hospital such as the dietitian may provide. I think the more active dietitians do this sort of counseling. And it would be included. Although it has not been singled out and identified on the bill as paying for health education. The purpose of our new program and the white paper is guidelines—to be able to single it out and put emphasis on it, and reimburse for it.

Mr. Carter. In going over the charts for payments which you put out, I don't believe I have seen payments for dietitians in there for their work. Do you include in your third-party payment, payments for health education other than that for the dietitian which you mentioned?

Mr. Carlson. I would think it is safe to say under our payments for outpatient benefits that there is this sort of work being done. It is probably being done more informally than saying we are paying for a health education clinic.

Mr. Carter. You still have a chart. I am sure you do, which states what you cover and what you send to a physician. You are Blue Cross, you take care of the hospital part of it—I should have your copartner here to ask those questions. Blue Shield pays the physician, and you pay for the hospital portion of it.

But you assure me that you do pay dietitians if they advise a diabetic while he is in the hospital?

Mr. Carlson. If they are doing that that would be included in our regular reimbursement.

Mr. Carter. You are sure that that has been done, and is being done?

Mr. Carlson. I think the most important aspect of that which relates to the question that was raised earlier about preventive care——

Mr. Carter. My questions is, is it done at the present time?

Mr. Carlson. To my understanding, if a dietitian is doing that we are paying for it.

Mr. Carter. I have never known of such an insurance. I would like to see a little of that for the record. If you are doing it, I congratulate you on that.

How do you anticipate that your health council would relate to the two entities described in one of the bills, National Center and HEW and private institutions, assuming that such become the law?

Mr. Carlson. I am sorry, are you talking about the role for private sector working with the Government institutions?

Mr. Carter. Yes, the National Center and a private institution provided in title No. 2 of H.R. 5839.

Mr. Carlson. You are talking about the contracts that would be given to private centers?

Mr. Carter. Would you supplant the private sector in title 2 of bill H.R. 5839?

Mr. **Carlson**. The role that we would envision for a private center working with the Government institute would be that such a center would be the proper locus for research in areas such as behavior modification for new methods, new innovative techniques that are needed in this field.

There is a lot that is being done right now without any measurement of whether it is actually truly affecting anyone's behavior. It is being done at random. I think there not only needs to be research about the effectiveness of what is being done, I think there needs to be new methodology investigated and where the payoff is going to be.

The people in Canada are not merely looking at the matter of total mortality statistics—they are trying to find out what it is that they could work on that is preventable and then, in turn, affect productive years of life lost. These are the areas they feel they should concentrate on. I think they need that not only in attacking the problem of motivation but inovations in defining the problem.

Mr. **Carter**. Do you think before we have innovations we should really study and plan, and do some research to see if our own innovative projects will be effective?

Mr. **Carlson**. Absolutely.

Mr. **Carter**. Or should we go ahead and take up our electric lines and streetcars lines, as we did before?

Mr. **Carlson**. Absolutely not.

Mr. **Carter**. The effect of that advertisement should be of value.

Mr. **Carlson**. Yes.

Mr. **Carter**. Do you think some of our advertisements have had an adverse effect?

Mr. **Carlson**. Yes.

Mr. **Carter**. Can you give any examples of these?

Mr. **Carlson**. I could even give you an example provided by a man who is considered to be an expert in behavior modification, Godfrey Hochbaum of the University of North Carolina, who believes that some of the health education advertisements based on motivation of fear, can be counter-productive.

I think one of the most successful programs we have had in advertising is a program using Fred Rogers who does the show on Public Television, "Mr. Roger's Neighborhood." We use this in the Pittsburgh area, and includes commercial messages which are put on during children's cartoon shows, which are helpful, reassuring messages trying to give them some of the basics of good health.

I think that there are general advertisements, product advertisements that can be counter-productive, but I think there are also some health education messages which have been given out previously, which could be counter-productive.

Mr. **Carter**. We had some testimony to this effect from Baylor Medical College, Baylor University. I thought it was very good. They showed us some of the television scripts that they had, some of them with Spanish that appealed to both—the Americans and to those of Latin American descent.

I think that perhaps Sesame Street might be used or, rather, that if we had someone of the ability of Joan Cooney—I believe that is her name, who is the originator of this—that perhaps she could help us along with very worthwhile advertisements in this area.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you so much for being here. We appreciate it.

Our next witness is Ms. Constance Holleran, deputy executive director, American Nurses Association in Washington.

We welcome you back.

STATEMENT OF CONSTANCE HOLLERAN, DEPUTY EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS DIVISION, AMERICAN NURSES ASSOCIATION

Ms. HOLLERAN. Thank you, Mr. Chairman.

In the interest of time I will make a very, very brief statement and ask that the full statement be made a part of the hearing record.

Mr. ROGERS. Without objection your full statement will be made a part of the record [see p. 403].

Ms. HOLLERAN. We do support the basic thrust of the legislation to improve health education for the country.

We are less than enthusiastic about the President's Commission on Health Education upon which some of the legislation is based, and we share some of the expressed concerns of that Commissions' minority opinions, especially in regard to the long-term financing potential for the nongovernmental center, and on the accountability of the center to the public.

We draw to your attention the lack of inclusion of nurses on that Presidential Commission, which we did object to at the time without success. We also feel the report did not adequately report the current ongoing health education efforts throughout the country.

Our statement describes in some detail the various roles in which nurses participate in health education as part of their daily work in hospitals, factories, homes and clinics. We would ask that you consider adding to your legislation in the final version, the participation of nurses in health education.

We endorse those efforts to promote the exchange of information among the health professionals and health education communities as a whole.

We ask that you continue your strong support of the concept of reimbursement for health education services. Being realistic—with the cost pressures in society, it is very unlikely that effective prevention programs can be maintained without some form of reimbursement.

I will close here.

[Ms. Holleran's prepared statement follows:]

STATEMENT OF CONSTANCE HOLLERAN, DEPUTY EXECUTIVE DIRECTOR, DIVISION OF GOVERNMENT RELATIONS, AMERICAN NURSES ASSOCIATION

I am Connie Holleran, Deputy Executive Director, Division of Government Relations, American Nurses Association. I am pleased to be here this morning to present the Association's views on the Health Education bills presently before you.

The scope of the proposed legislation being considered here today varies greatly. Each bill, we believe, has certain positive features. I would like first to speak to nursing's role in health education and then focus on specific aspects of these bills.

As the demand for comprehensive health care grows, there is an increased awareness of the role of health education in promoting a better quality of life. There is also a greater recognition that the consumer is the best health care resource and that he has a right to information about his health and health problems. Therefore, the consumer has a right to information about preventive health measures and corrective measures for health problems. In the past, infectious disease prevention was the primary focus of health education. Now, health education has expanded from the teaching of principles of hygiene and safety to the dissemination of knowledge, function and skills that are necessary for both individuals and groups to cope with illness. Promotion of wellness is a focus of health education activities. In these days of cost effective interests, the long term savings of such efforts are obvious.

Health education is a process incorporating intellectual, psychological and social dimensions. The process is based on scientific principles and facilitates behavioral change. It is the communication of facts designed to provide a knowledge base for health activities. The activities are aimed at increasing the ability of consumers to make informed decisions affecting their personal, family and community well being.

The registered nurse is prepared to assume the health teaching responsibility through educational preparation and expertise. Beginning skills are learned in a baccalaureate nursing program. These skills include assessment, planning, implementing and evaluating nursing care. Psychology and sociology are included in the curriculum as well as basic principles of communication, interviewing and counseling.

To assume responsibility for development, operation and evaluation of coordinated and integrated health education programs, the nurse is educationally prepared. Preparation includes formal courses that provide an understanding of and are directed toward development skills in the following areas:

1. Teaching and learning principles.
2. Counseling techniques.
3. Adult and childhood education.
4. Curriculum development.
5. Implementation and evaluation.
6. Cultural attitudes and behaviors toward health.
7. Teaching methodologies, compliance, role theory, behavior modification, role modeling, compliance, grief, denial, anger, acceptance, depression and coping.
8. Dynamics of change.
9. Establishing relations with and among different health disciplines.
10. Communications: groups and interpersonal.
11. Use of audiovisual equipment.
12. Identification and use of community resources.
13. Simple research methodology.

Health education is an inherent and ongoing part of nursing care in every setting. Hospital and community health nurses have traditionally taught patients specific skills such as colostomy care and insulin administration, diabetic diet, things to watch for wth specfic medications, and so on. Professional nurses have promoted optimum functioning through health education for prevention as well as for illness. Prenatal and newborn care, which is basic to helping families develop good health habits at a crucial time of life, has been routinely taught to mothers by nurses. Knowledge in the areas of adjustment to disease and physical alteration is taught both formally and informally to individuals and groups. Within the last five years, definitions in licensure laws have specified patient/client teaching as one of nursing's functions—a legal commitment to a traditional responsibility.

As a health care provider, every professional nurse is responsible and accountable for the quality of nursing care the patient receives. This includes the responsibility and accountability for teaching the patient relevant facts and attitudes about specific health care needs.

The nurse is in a key position to promote the development of health education programs in industry, health maintenance organizations, hospitals, nursing homes, physcians' offices, outpatient clinics, home health community mental health centers, state and local departments, schools, and in private practice settings.

Nursing's teaching is directed towards health maintenance, towards prevention of disease and its complications and towards promotion of early return to maximum function following illness.

In the school setting, the nurse is nearly always the only health care provider who is in attendance. In the role of school nurse, he/she provides health education to students, faculty and parents. School nurse practitioners can assume a major role in health education, case finding and counseling.

The visiting and public health nurse spends a large portion of his/her time in health education—teaching families how to care for a chronically ill family member; teaching a patient insulin administration, proper diet, untoward symptoms and hygiene, teaching a newly diagnosed tuberculosis patient the importance of disease control and treatment; and etc.

There are a growing number of nurse-run, primary care clinics. These are often clinics attended by patients with chronic conditions such as diabetes and hypertension. A prime goal of the nurse working in these clinics is helping the patient understand the condition and the importance of following the treatment regime. This is achieved through health education.

Many patient education articles have been published by nurses. For example, 'Primary Hypertension Patients' Learning Needs," *American Journal of Nursing*, Vol. 73, No. 4, 4–73; "A Teaching Program for Diabetes," *American Journal of Nursing*, Vol. 73, No. 1, 1–73; and "Sx Education on a Psychiatric Unit," *American Journal of Nursing*, Vol. 74, No. 10, 10–74. A publication by the HEW's Division of Nursing, "Nursing Research Field Center in San Francisco called "Feet First" was done by nurses for use in patient education. The demand for this publication has been great and it is now available in Spanish as well as English. A study, "Commune Health Education," made possible through a HEW, Division of Nursing grant, considered how health education in the commune milieu could be more effective. This study focused on preventive health education.

We believe the professional, registered nurse is educated to provide high quality health education. And, the R.N. is providing health education in nearly every nursing care setting. Nursing practice standards established by the American Nurses' Association stress consumer participation in health promotion, maintenance and restoration. Therefore, we believe the expertise of the R.N. can be of great benefit to the development of health education programs.

We notice that none of the bills before you specifically mention nursing's role or call for that expertise on the Advisory Councils. We believe this is to the detriment of any attempts to make health education a meaningful and effective program. In the Senate report on their Health Education bill, they state that "nursing is the one profession that is doing the most consumer health education in the United States today . . ." We urge, therefore, that professional nurses be mandated in the Advisory Councils called for by the bill the committee reports out. It is most interesting to note that all the bills call for physician representation despite the fact that in the majority of health care facilities where physicians and nurses work side by side, it is the R.N. who actually provides the health education. How many physicians have you heard of who teach diabetic classes or assist the individual patient in learning about and caring for his/her colostomy?

H.R. 3205 seems to us to speak most directly to health education and would provide a basic framework for a Federal thrust into health education. Health education is an important aspect of health care, and I stress aspect. We need to continue to find out more about motivation and how to maximize health education's usefulness, but we must not pin our hopes on health education at the expense of other preventive programs or at the cost of providing services to the ill.

We believe a study of cost benefits of health education is important but question the appropriateness of comparing health education with "other health services programs" as specified in H.R. 3205. We would applaud the emphasis on cost effectiveness as provided for in H.R. 8278. This focus could provide information which would move health education in the appropriate direction—where the greatest benefit could be gained.

The ANA would like to point out that there was an extensive study of health education commissioned in 1971. Its "Report of the President's Committee on Health Education," was published in 1973. Despite our objections, no nurse was appointed to that Committee. There were numerous dissenting statements to the final report and it appears that very little positive action has ever resulted from the study; moreover, we are concerned about the cost and time involved in yet another study, as called for in SEC. 1704 of H.R. 3205. We question whether or not there is any real value to be gained from such an undertaking.

The needs for health education vary with age, geographic location, culture, oc-
another study, as called for in Sec. 1704 of H.R. 3205. We question whether or
cupation, health status, family composition, role, lifestyle and resources. Sections 1704 and 1705 of H.R. 3205 both recognize these variances in health education needs and we believe this is a positive aspect of that bill.

Health education programs are, by nature, interdisciplinary. It is essential that there be close collaboration among all health disciplines in maximizing its potential. Section 103 of H.R. 5839 speaks to a bringing together of all major health education organizations to share ideas, identify gaps and overlaps and find ways for cooperation. We believe that not only should these groups be brought together but also included should be all the organizations and groups involved in providing health education. For example, it is extremely important that those such as dietitians, pharmacists and nurses involved in health education have their valuable ideas included.

Just as health education programs require interdisciplinary inputs, the nurse is very much aware that health education cannot be entirely isolated. For example, it is impossible for the registered nurse to divorce the teaching aspects of a communicable disease program from the control aspects. Likewise, it is impossible to provide comprehensive care to the hypertensive or diabetes patient without providing a great amount of health education.

The proposed health education bills seem to fail to consider this integrity or the current health education which health practitioners are already providing. It may be worthwhile to provide a Center and/or Institute to add impetus to this much needed area but it is not practical or possible to separate health education from operational programs.

We believe the focus in any health education impetus should be on a coordination of effort among providers, on a small special office to prod HEW and others toward health education and perhaps most importantly toward a sharing, by all the professions involved, of knowledge gained and new areas to be researched.

All 3 bills speak to the need for coordination of health education knowledge and techniques among health education providers. This we believe is worthwhile and should be undertaken. The need for such a sharing of knowledge among health educators is evident.

Part B. of H.R. 5839 calls for the establishment of a nonprofit corporation. However, to have a National Center within HEW and a nongovernmental "Institution" seems to provide the groundwork for redundancy and a lack of coordination. Although the "Institution" is to submit an annual report to the President for transmittal to Congress (which seems to be the only possible coordination between the two education centers) there is no provision for the Institute to include its goals and objectives in its report or for a coordination of efforts. Also, since its Board of Directors is to be appointed by the President, with the advice and consent of the Senate, it could be questioned as to its nonpolitical nature.

Another area of concern is Section 102 of HR 5839 which calls for the Secretary, acting through the Center, to recommend appropriate educational and certifying policies for health education and preventive medicine manpower. The ANA would take strong exception to the Secretary recommending such policies. Graduate and undergraduate nursing programs are accredited by the National League for Nursing. The accrediting process for continuing education and expanded role nursing programs is being developed by the ANA. We believe that non-governmental bodies are most appropriate for accrediting and we would object strongly to the Secretary setting these policies.

We have stated that health education should be based on scientific principles and outlined the educational preparation of the professional nurse to assume this role. We would be concerned about a national program focusing on health education causing proliferation of poorly prepared or unqualified "health educators". This is not to say that there is no place for health educators in certain programs. The bills do not define the role or scope of responsibilities intended for personnel being prepared.

In closing, I wish to point out that this profession has long been actively engaged in preventive health care and health education. We have attempted for years to obtain reimbursement for the health education activities of nurses but third-party payors, on the whole, have turned a deaf ear. Some are beginning to reimburse health education activities identified as a part of a specific treatment plan. The ANA supports reimbursement to qualified providers for health education activities when they are conducted as a part of a treatment regime or in an organized program such as obesity clinics, no-smoking classes, etc. Perhaps these hearings on this vital aspect of health care, and I stress health care, not just medical care, will bring the recognition needed for reimbursement of these services, including those of nurses.

I thank the Subcommittee for its attention.

Mr. Rogers. Thank you so much.

Dr. Carter.

Mr. **Carter.** It is always a pleasure to have you here.

Thank you.

Mr. **Rogers.** The points you made are very valid, and unless this service can be paid for in some way we won't have that service long.

Thank you so much. It was most helpful.

Our last witness today is Dr. Thomas G. Dorrity, board of directors of the American Physicians and Surgeons. He will be accompanied by Mr. Frank K. Woolley, executive director.

STATEMENT OF THOMAS G. DORRITY, M.D., BOARD OF DIRECTORS, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.; ACCOMPANIED BY FRANK K. WOOLLEY, EXECUTIVE DIRECTOR; AND MAURICE A. KRAMER, ASSISTANT EXECUTIVE DIRECTOR

Dr. **Dorrity.** I have Mr. Maurice Kramer of our Washington office. I would like for him to sit in.

Mr. **Rogers.** Certainly. We welcome you, Mr. Kramer.

Dr. **Dorrity.** I am Thomas G. Dorrity, a practicing surgeon in Memphis, Tenn., and chairman of the legislative committee of the Association of American Physicians and Surgeons.

Accompanying me is Frank K. Woolley, executive director of our association, and Mr. Maurice Kramer, of our Washington office.

The association is a free, independent, nongovernmental voluntary organization of members of the medical profession, united for the purpose of analyzing the profession's problems and formulating actions to improve medical care for all Americans, preserve freedom of choice for patient and doctor, protect the practice of private medicine, and educate physicians and the public to recognize and defeat schemes that would weaken or destroy our free-choice system of medical care.

We welcome this opportunity to testify in opposition to proposals to politicalize yet another area of our free-choice society—the area of health education.

The testimony on proposals to enact a so-called National Health Education Act, as the testimony at the hearings now being held on proposals deceitfully called National Health Insurance, may be especially timely and useful to members of this committee, and to others as well.

Those who are now developing plans and platforms for candidates for Congress, for example, may find in this testimony many incisive ideas for coming campaigns. Positions on proposals to politicalize health and medical care will doubtless be frontline issues in many election year battles.

As you know, rapidly growing resentment toward big spending and bureaucratic government now precludes any assumption that passage of such proposals is inevitable. It is increasingly clear, for example, that so-called national health insurance is a big spending idea whose time has come—and gone.

We believe that the climate in many congressional districts for risking another bureaucratic boondoggle to be called the National Health Education Act may be very "cloudy." Judging from reactions throughout the country to the current fiscal crisis in New York City, voters will take a very hard look at all platform rhetoric in behalf of a bigger bureaucracy.

You are aware of this growing skepticism, of course. It was reflected in news reports on last week's vote on a new consumer-protection agency. Even the Washington Post emphasized that the vote indicated "growth of antibureaucracy sentiment in Congress."

Further evidence of back-home irritation from bureaucratic bungling is the new push in Congress for veto power over regulations issued by Federal bureaus. It may make more sense to many voters, however, if Congressmen—and candidates for Congress—indicate interest in birth control on legislation that authorizes new reams of rules and regulations.

BACKGROUND

We believe that those who read the record of the testimony on proposals to pass a National Health Education Act should have the benefit of a broader perspective than that provided by proponents of the proposals. Some of the following comments and questions on background and related developments may aid in evaluating the arguments of these proponents.

For example, it is significant that while this committee of Congress considers proposals to create a mechanism for central government subsidy and control of health education activities, another committee is continuing the campaign to push through Congress some compromise version of proposals for compulsory politicalized medicine—so-called national health insurance.

While sponsors of principal proposals before the House Ways and Means Committee are labor unions, hospitals, doctors (AMA), and health insurance companies, it is important to note that major forces pressing for compulsory politicalized medicine include those trying to politicalize health education. A comparison of witness lists and analysis of testimony will emphasize this important point.

We are all indebted to Senator Kennedy for a new source of illumination of the relations between health education bills and national health insurance bills. This new source of illumination is the report on Senator Kennedy's bill S. 1466, issued by the Senate Committee on Labor and Public Welfare on July 24, 1975. It is Senate Report No. 94–330. We urge members of this committee to study this report carefully, and urge everyone concerned with health issues to ask their Senator or Congressman to obtain a copy of this report for them.

Based on our study of Senate Report 94–330 and its implications, we have warned members of our association, and others, that S. 1466, if passed, would:

Establish HEW as the arbiter of individual behavior, deciding how people should behave, and taking action to force changes in their behavior to fit bureaucratic ideas.

Arm HEW and its agents with authority to use health education as a propaganda vehicle to undermine private, free choice medicine to help "reorganize and restructure our health services delivery system, and financing mechanisms".

Give HEW authority to use health education projects as a device to meddle with the quality of medical care.

Empower HEW to use health education as a weapon to attack private health insurance as a means of promoting compulsory politicalized medicine.

Let HEW use health education as an excuse for dabbling with "biological-genetic factors" affecting health;

Direct HEW to pressure medical, dental and nursing schools to include Government approved education and promotion courses as part of their curricula.

> Confer on HEW the power—superseding the FCC—to intimated TV networks into carrying government prescribed health education programs.
>
> Authorize HEW to employ censure by publicity, "nongovernment sanctions and all the moral and political power it commands" to compel the advertising industry—including radio, television, newspapers and magazines—to elminate material for advertising deemed "by objective professional opinion" to me "injurious to the nation's health".
>
> Instruct HEW to cut off Federal grants and medicare and medicaid funds to hospitals unless they force-feed government devised health education to all inpatients and outpatients.
>
> Grant HEW, in the name of health education, the extraordinary power to intrude into Federal programs in agriculture—to eliminate Government support for harmful or potentially harmful products like tobacco and "beef with high fat content"—and into Federal programs in housing, transportation and energy, and even into local police matters.

We have urged our members, and others, to consider the full implications of this statement in the committee report on S. 1466:

> Direct governmental efforts to modify citizens' behavior, mass media content, and school curricula in ways that are scientifically sound, effective and culturally acceptable represent extremely difficult issues. On the one hand, the current state of the art of health education is probably inadequate to deliver effective and reliable results in the public interest from such interventions. On the other hand, to be effective, such actions by a Government agency may conflict with constitutionally guaranteed private freedoms.

Nothing in S. 1466 or the committee report on it indicates efforts to make sure that HEW cannot use this legislation to violate constitutionally guaranteed private freedoms. Rather, the bill proposes to use private citizens and organizations in a Government-directed campaign to soften up people to accept the assault on their constitutionally guaranteed private freedoms.

The report explains that:

> Organized private action is needed to explore controversial issues and develop national guidance which reflects a general professional and consumer consensus on appropriate and acceptable directions of effort.
>
> Because such private policy does not have authority to compel compliance, it must necessarily include development of voluntary support and resolution of realistic constraints which are a fundamental part of the problem. Once the efficacy and acceptability of such privately developed initiatives has been demonstrated, then the need for and the exact nature of additional governmental support to extend implementation will be both clearer and less likely to encounter opposition.

The basic goal of using health education as a weapon to undermine private, free-choice medicine is made clear in this statement in the committee report on S. 1466:

> The cluster of concerns outlined and described in this report urge us to continue our efforts to reorganize and restructure our health services delivery system and to continue to experiment with innovative financing mechanisms.

We sincerely hope that the preceding excerpts from Senate Report No. 94–330, and our interpretations of them, will be useful background for consideration of similar bills before this committee.

We wish to submit, also, the following charts and comments relating to fiscal aspects of the proposed subsidies of health-education activities—and to other health-related proposals this committee may consider. We feel sure that these charts and comments will be helpful to you, and to the many others we hope will make maximum use of this testimony.

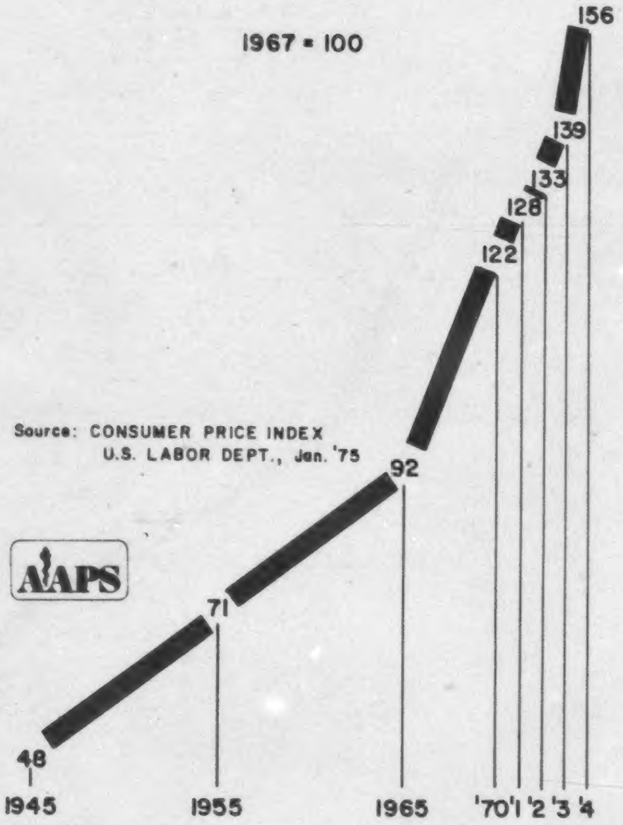
It is a fact that Government controls that which it subsidizes. It is a fact that Government expenditures are out of control. It is a fact that Government expenditures should be cut, not increased. It is a fact that Government standardization means control and violates the diversity which is one of our country's unique sources of strength.

PSRO is a case in point. Medical review undertaken by physicians voluntarily without Government subsidy or control of private initiative can answer many problems without great expenditure of money. Therefore, for these reasons Government should not pass any legislation in this area.

Thank you.

[The attachments to Dr. Dorrity's statement follow:]

INFLATION

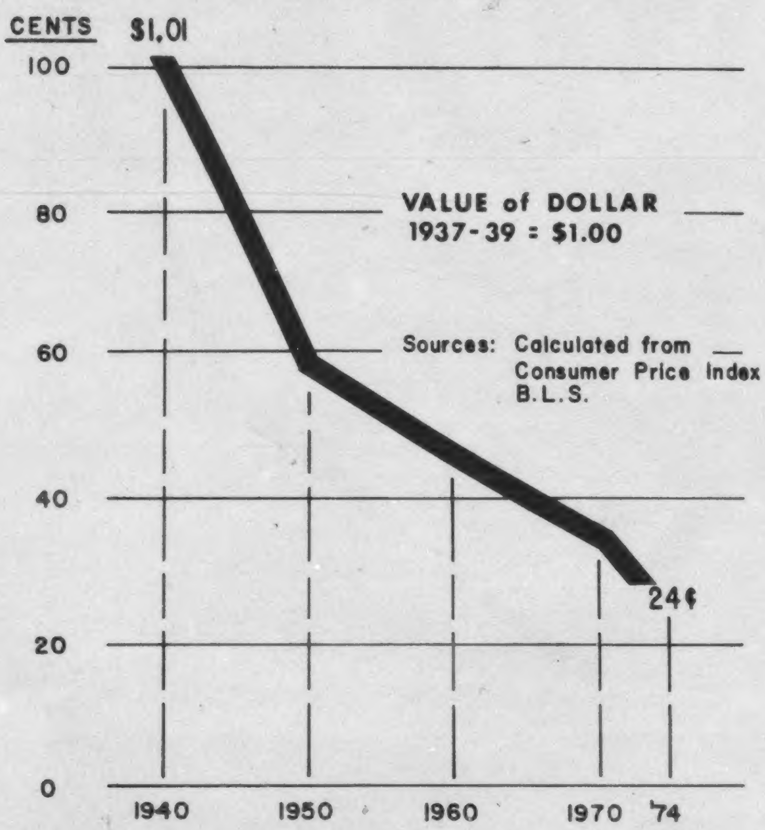


Source: CONSUMER PRICE INDEX
U.S. LABOR DEPT., Jan. '75

"This chart shows that the inflation index has risen over three times since 1945 -- from 48 to 156. Though this thermometer reading of the body politic may not be fully understood by all, the next chart brings into sharp focus the 'long view of legalized thievery' that has been going on since 1940."

AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

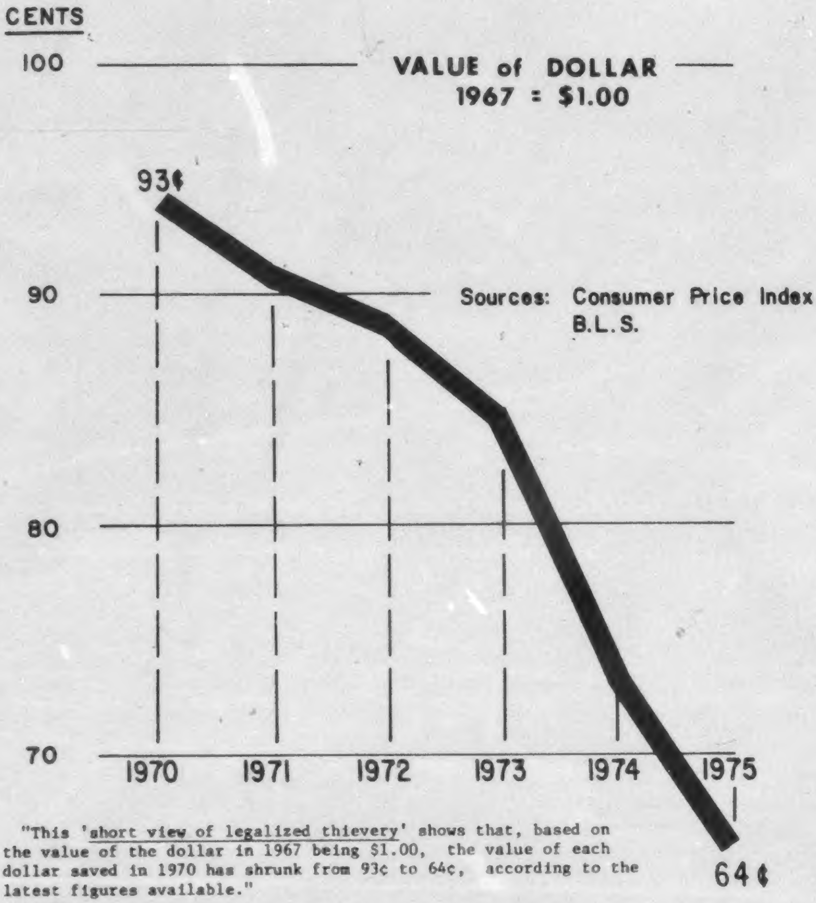
Long View of LEGALIZED THIEVERY



"This chart shows that the value of the dollar has shrunk from a 1940 value of $1.01 to 24¢ in 1974. This means to the elderly and disabled that from every $1.01 saved in 1940, 3/4 of the value of these savings has been stolen by inflation."

AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

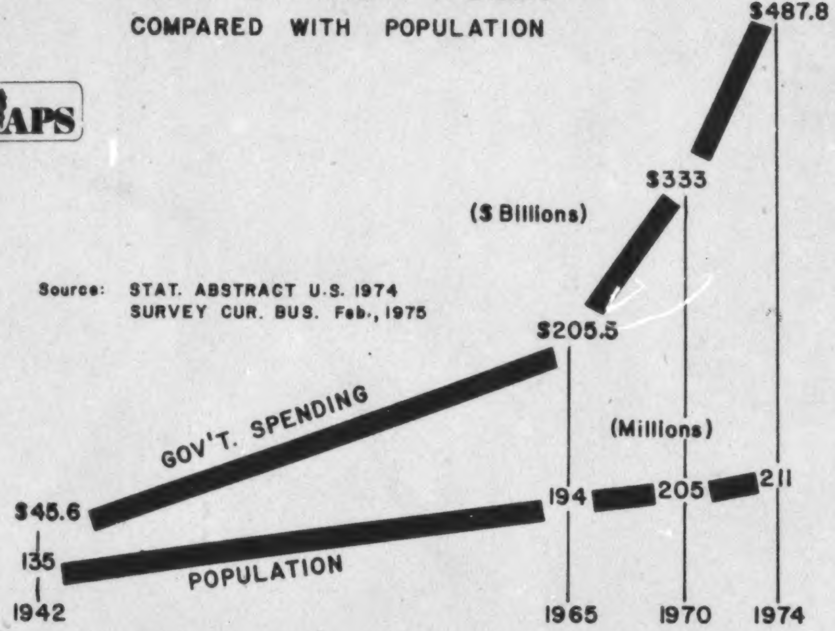
Short View of LEGALIZED THIEVERY



"This 'short view of legalized thievery' shows that, based on the value of the dollar in 1967 being $1.00, the value of each dollar saved in 1970 has shrunk from 93¢ to 64¢, according to the latest figures available."

AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

TOTAL GOVERNMENT SPENDING COMPARED WITH POPULATION



Source: STAT. ABSTRACT U.S. 1974
SURVEY CUR. BUS. Feb., 1975

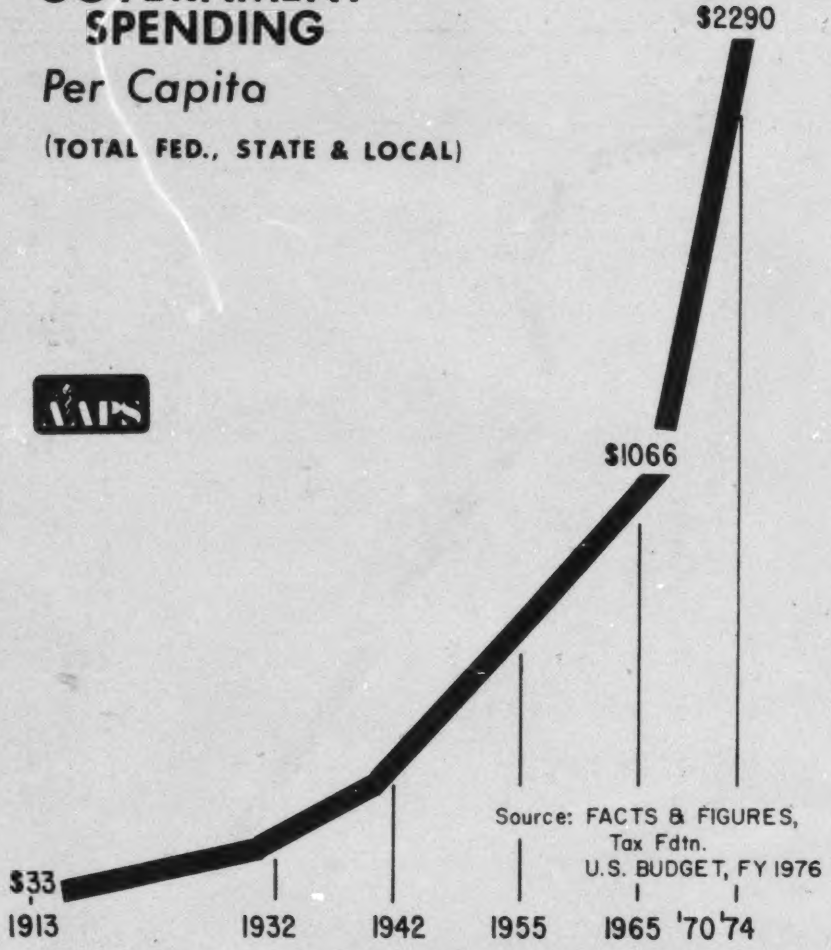
"This chart compares government spending with population, and shows that government spending increased from $45.6 billion in 1942 when the population was only 135 million to $487.8 billion in 1974 when the population was estimated to be about 211 million."

AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

GOVERNMENT SPENDING

Per Capita

(TOTAL FED., STATE & LOCAL)

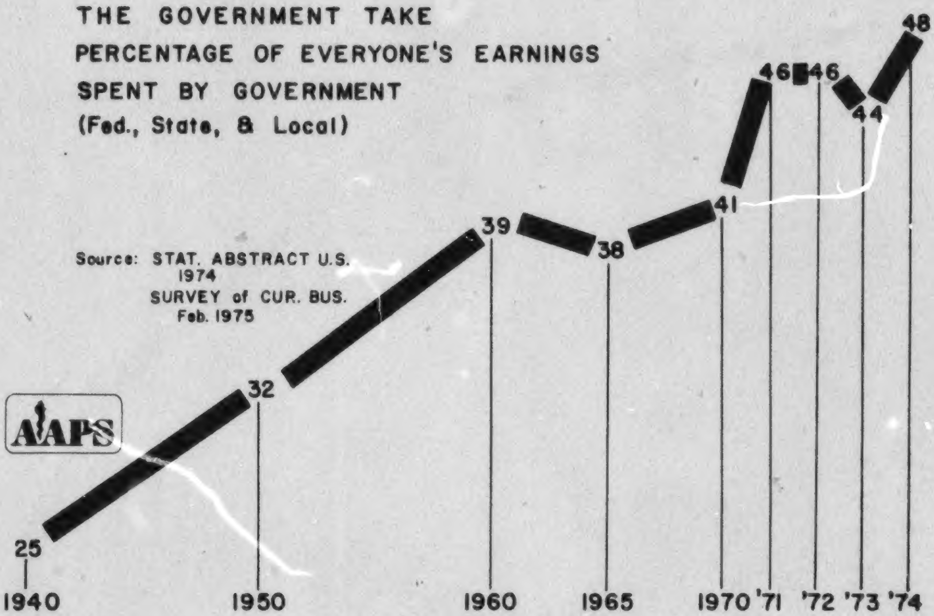


Source: FACTS & FIGURES,
Tax Fdtn.
U.S. BUDGET, FY 1976

"This chart shows how government spending per capita -- federal, state and local -- went up from $33.00 per person in 1913 to $1,066 per person in 1965; and then on up to $2,290 per person in 1974. The enormity of government spending is emphasized by per-family figures -- multiplying $2,290 x 4 shows that annual government spending per family is now over $9,000!"

AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

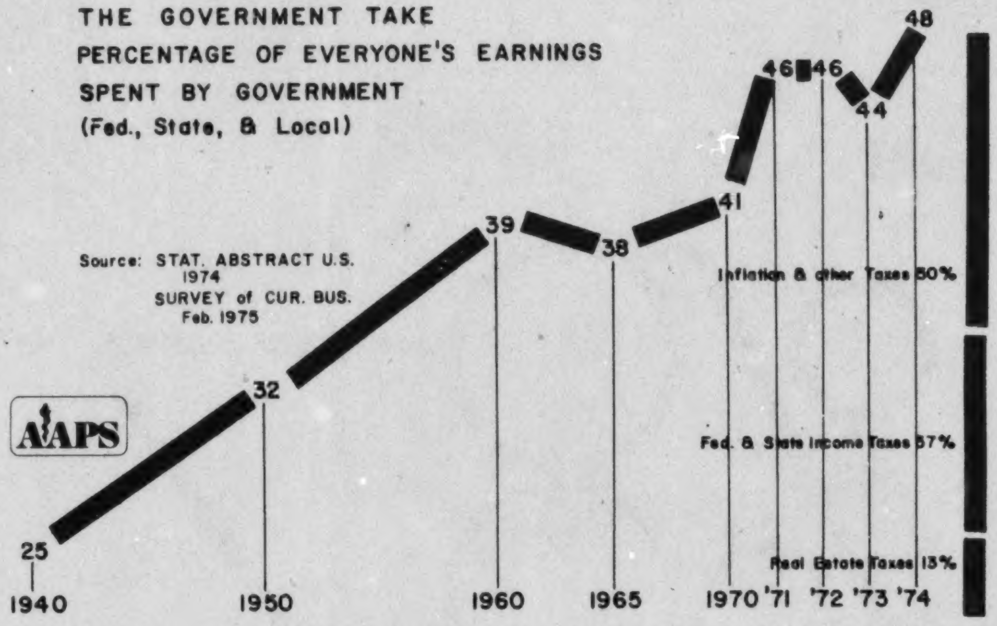
THE GOVERNMENT TAKE
PERCENTAGE OF EVERYONE'S EARNINGS SPENT BY GOVERNMENT
(Fed., State, & Local)



Source: STAT. ABSTRACT U.S.
1974
SURVEY of CUR. BUS.
Feb. 1975

"This chart shows the 'government take' -- the percentage of everyone's earnings spent by government. In 1940, 25% of everything everyone earned was spent by government. But by 1974, the 'government take' had risen to 48%! Some may find this hard to believe, for such facts are often clouded by deceit, misrepresentation and deliberate schemes to keep people from realizing the truth."

AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75



THE GOVERNMENT TAKE
PERCENTAGE OF EVERYONE'S EARNINGS
SPENT BY GOVERNMENT
(Fed., State, & Local)

Source: STAT. ABSTRACT U.S.
1974
SURVEY of CUR. BUS.
Feb. 1975

"This chart shows that 13% of the 'government take' came from real estate taxes, 37% from federal and state income taxes, and the balance from inflation and other taxes. While the federal and state income taxes of the average person amounts to about 18% or 19% of his total income, when other taxes are added in the total amounts to 48%."

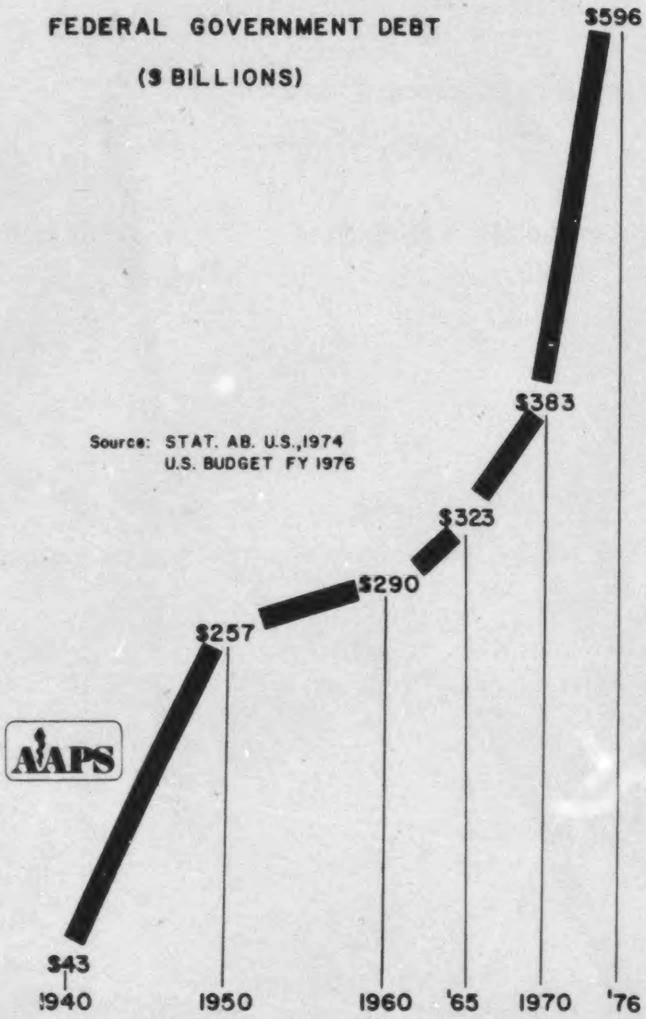
-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

48%

AAPS

"This emphasizes the important point that 'government take' is now 48%! Data in the Survey of Current Business of the U. S. Department of Commerce -- cutting through all the red tape and confusion about authorizations, outlays, trust funds and other minutia connected with government red tape -- shows clearly that government spends 48% of the total earnings of everyone."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75



FEDERAL GOVERNMENT DEBT

($ BILLIONS)

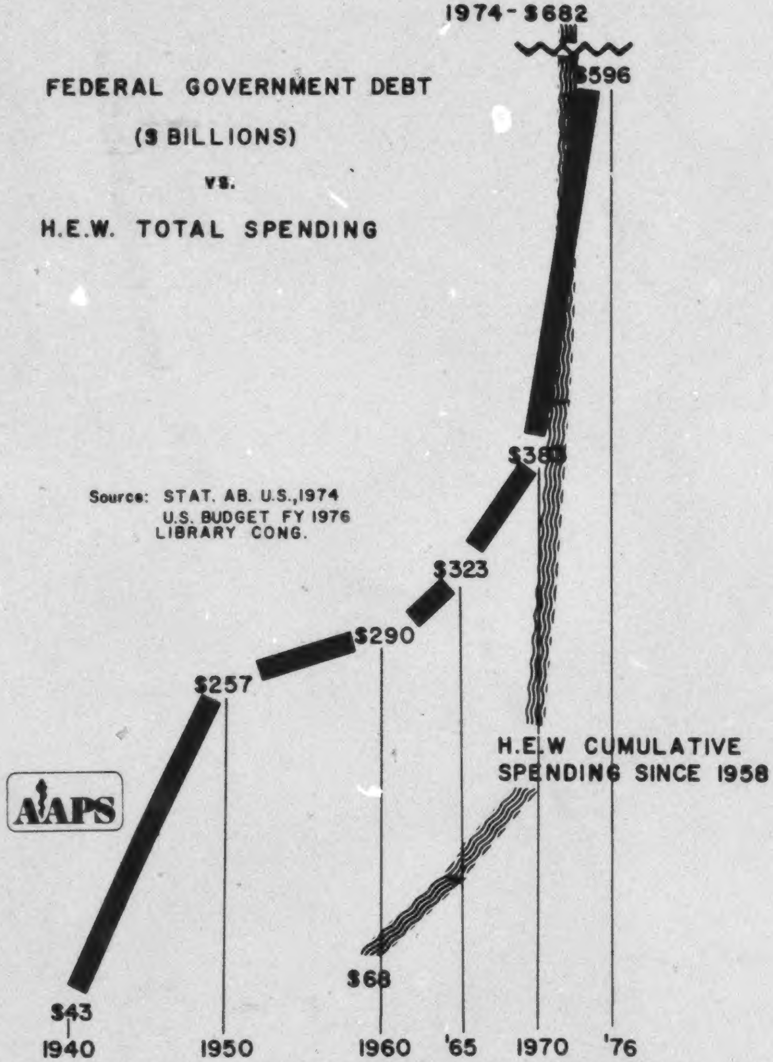
Source: STAT. AB. U.S., 1974
U.S. BUDGET FY 1976

"This chart shows that wild government spending has increased the public debt from $43 billion in 1940 to $596 billion in 1976. The Secretary of Treasury says the federal government will have to borrow $70 billion in this fiscal year, and may have to borrow $86 billion more in fiscal 1976. This will mean that the government can do only one thing: run the printing presses!"

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

10.

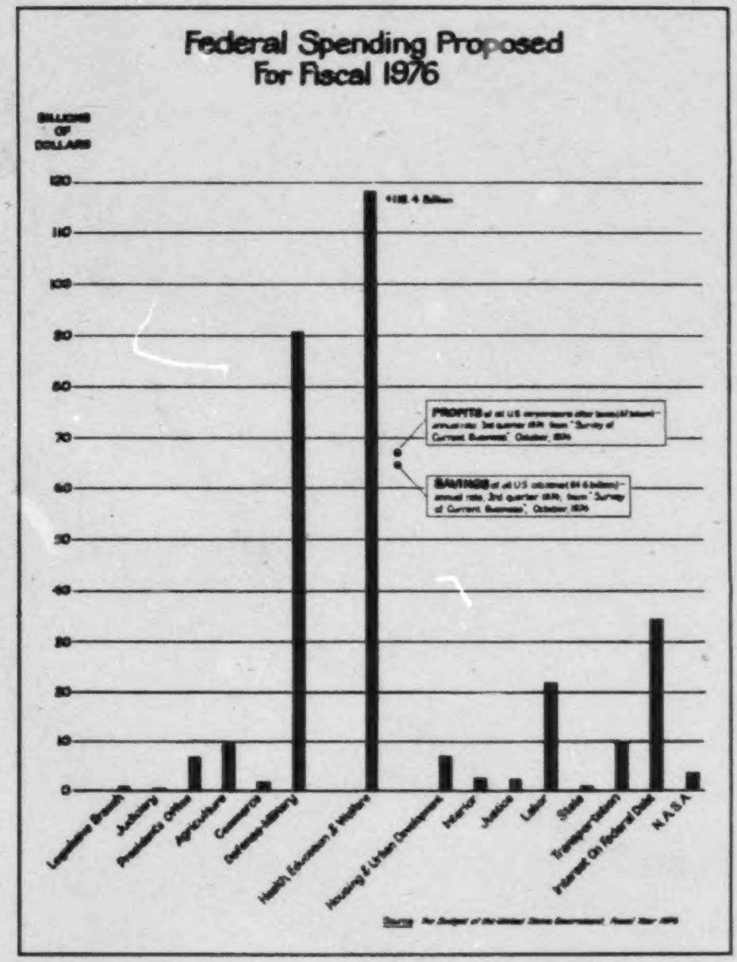
FEDERAL GOVERNMENT DEBT
($ BILLIONS)
vs.
H.E.W. TOTAL SPENDING



Source: STAT. AB. U.S.,1974
U.S. BUDGET FY 1976
LIBRARY CONG.

"This chart shows that the cumulative spending of HEW since 1954 is $682 billion. This is $86 billion more than the total indebtedness of the United States. This means that HEW has spent $3,232 per person for every man, woman and child in the United States -- more than $12,000 for every family of four. The HEW cumulative-spending curve now stands almost vertical!"

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75



Source: The Budget of the United States Government, Fiscal Year 1976

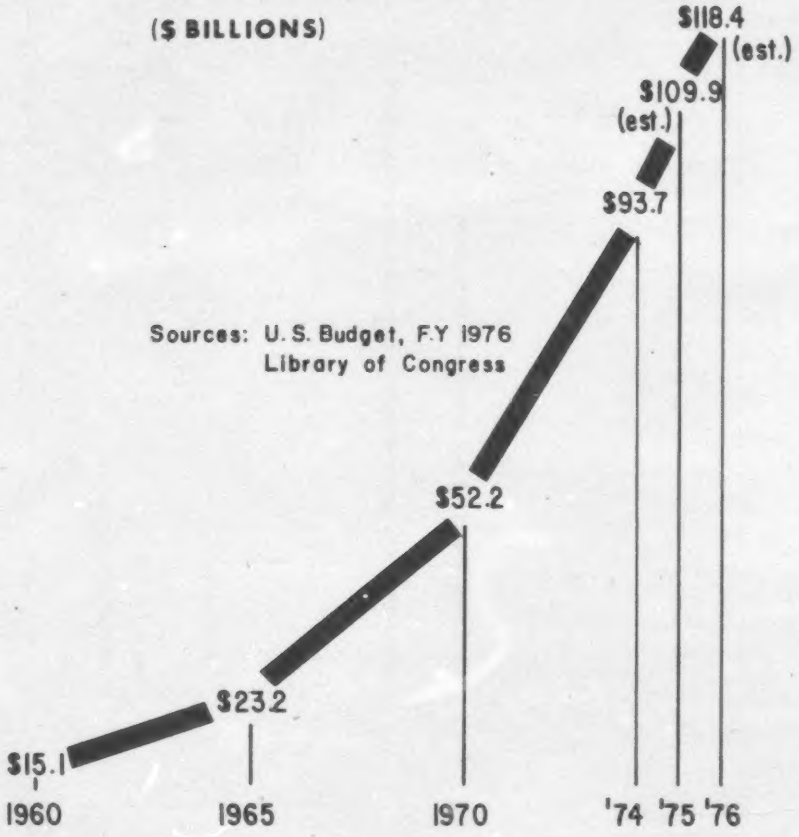
"This chart shows the enormity of HEW spending in relationship to spending for defense, interest on the debt, the space program, and other major departments; and that HEW spending is almost double the $64.6 billion annual rate of savings of all citizens reported in Oct. 1974. Obviously, HEW can continue its unbridled spending only through use of printing-press money."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

H.E.W. Spending

($ BILLIONS)

AAPS



Sources: U. S. Budget, F.Y 1976
Library of Congress

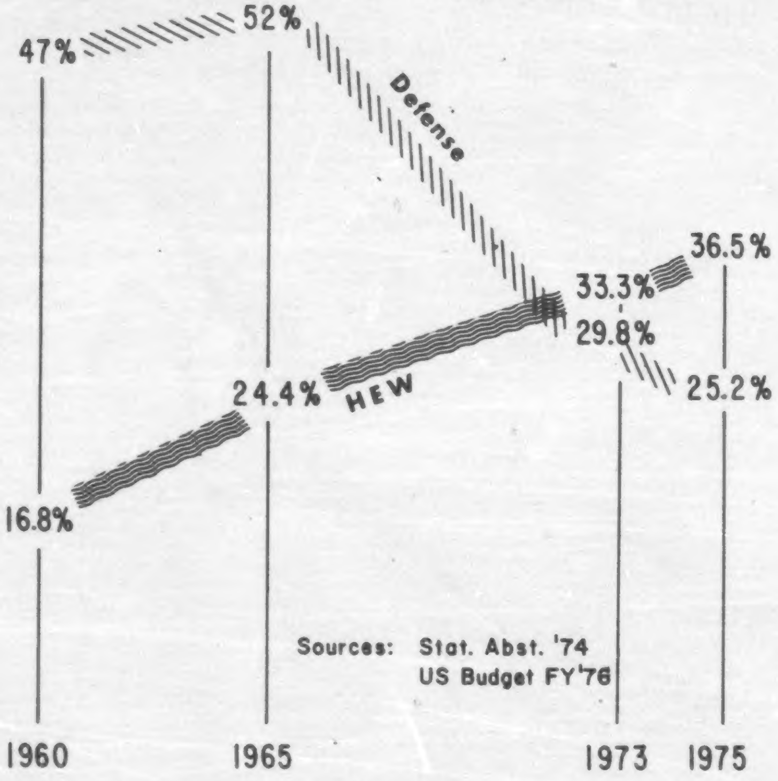
"This chart shows that HEW spending has gone from $23.2 billion in 1965 to $118 billion in 1976."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

AAPS

HEW vs Defense

PERCENTAGE OF TOTAL FEDERAL SPENDING



Sources: Stat. Abst. '74
US Budget FY'76

"This chart shows HEW spending in relationship to spending for defense. In 1960, 47% of all federal spending was for defense, and only 16.8 was for HEW. Now, HEW spending is 36.5% of total federal spending, and defense spending is less than 25%."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

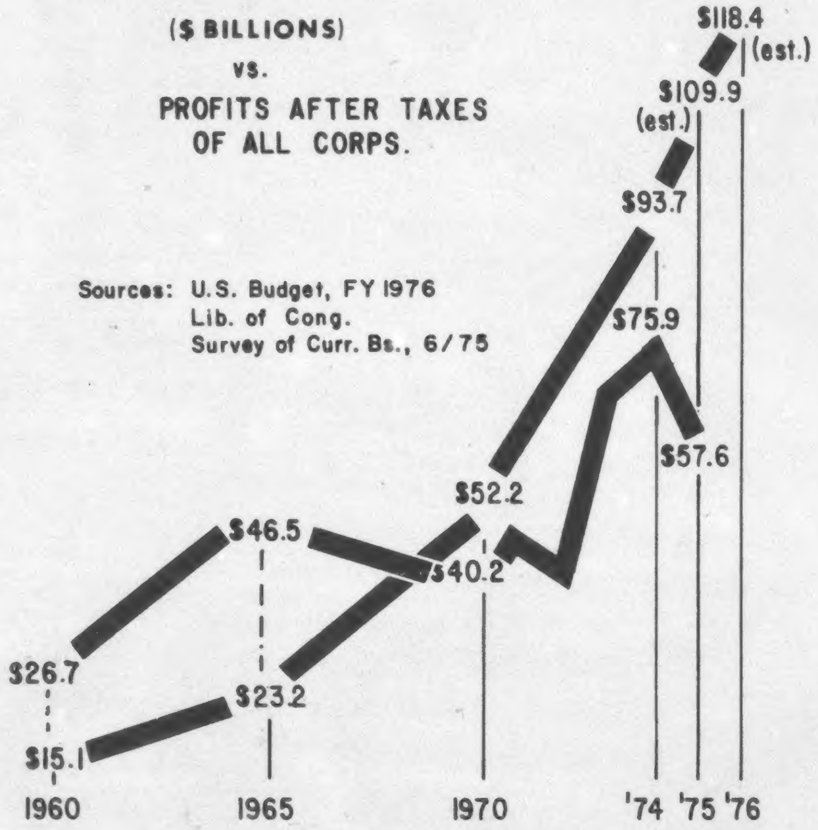
AAPS

H.E.W. Spending

($ BILLIONS)

vs.

PROFITS AFTER TAXES OF ALL CORPS.

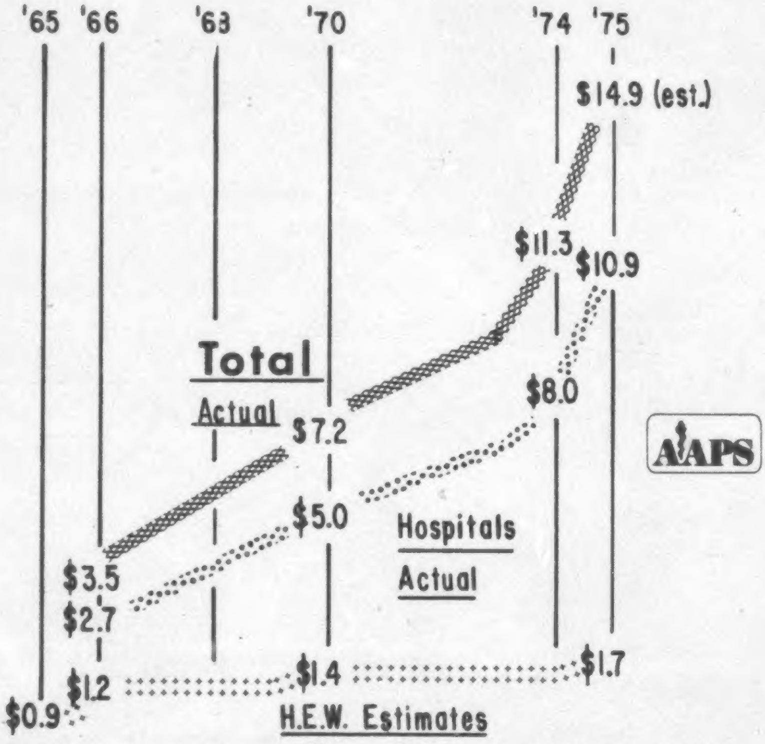


Sources: U.S. Budget, FY 1976
Lib. of Cong.
Survey of Curr. Bs., 6/75

"This chart shows that in 1960, profits after taxes of all corporations in the United States were $26.7 billion, and that HEW spending was much less. But in 1974, HEW spent more than all the profits after taxes of all corporations. In other words, if all the income of all corporations were confiscated -- this amount would not now pay for HEW spending.

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

MEDICARE COST
ESTIMATED v ACTUAL
(Billions)



"This chart shows that in estimating Medicare costs, HEW actuaries promised on a pile of statistics that in the first year of operation, it would cost only $900 million -- and that the cost would gradually go up to $1.7 billion in 1975.

"While there were strong objections by doctors and others to the acceptance of these HEW Medicare-cost estimates, Congress at that time apparently did not see through the misrepresentations and chicanery of the bureaucracy, and irresponsibly chose to believe the bureaucratic sooth-sayers who had an interest in betraying the people.

"Actual hospital costs the first year were more than double the amount HEW promised, and are now $10.9 billion per year. When supplemental medical program costs are added, total annual Medicare costs are now estimated at $14.9 billion."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

MEDICARE COSTS

(HOSPITAL)

ESTIMATED V ACTUAL

ACTUAL IN 1974 WAS 6 TIMES THE ESTIMATED COST

SOURCES:

1. ACTUARIAL STUDY NO. 57
   SSA - H.E.W. JULY 1963, PAGE 25
   W & M HEARINGS MEDICAL CARE FOR AGED
   HR 3920, NOV. 1963, P. 197
2. BUDGET OF U.S., FY 1975
   SPECIAL ANALYSIS PAGE 148
3. BUDGET OF U.S., FY 1976
   SPECIAL ANALYSIS PAGE 183

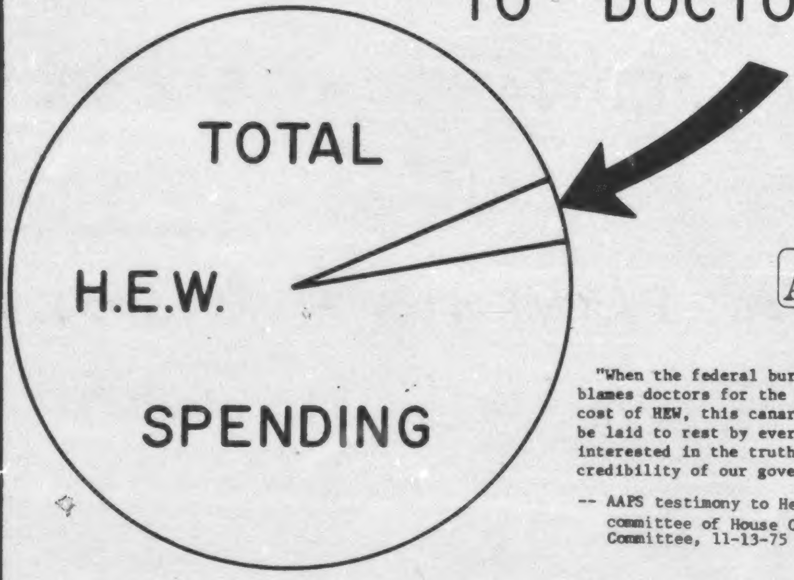
AAPS

"Comparing the Medicare-cost estimates of HEW with the actual costs in 1974, actual hospital costs were 6 times the promised costs -- and actual total costs were nearly 9 times the cost estimates of HEW!

"These comparisons should be significant to members of Congress in evaluating HEW cost estimates of pending proposals for so-called national health insurance -- and related schemes."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

PERCENTAGE OF PAYMENTS TO DOCTORS FOR MEDICARE AND MEDICAID OUT OF TOTAL H.E.W. SPENDING



ONLY 3.3%
TO DOCTORS

AAPS

"When the federal bureaucracy blames doctors for the increased cost of HEW, this canard should be laid to rest by every person interested in the truth and the credibility of our government."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

TOTAL H.E.W. SPENDING FOR 1974 = $ 97 BILLION

AAPS

PAYMENTS TO DOCTORS IN 1974:

FOR MEDICARE = $ 2.595

FOR MEDICAID = .656

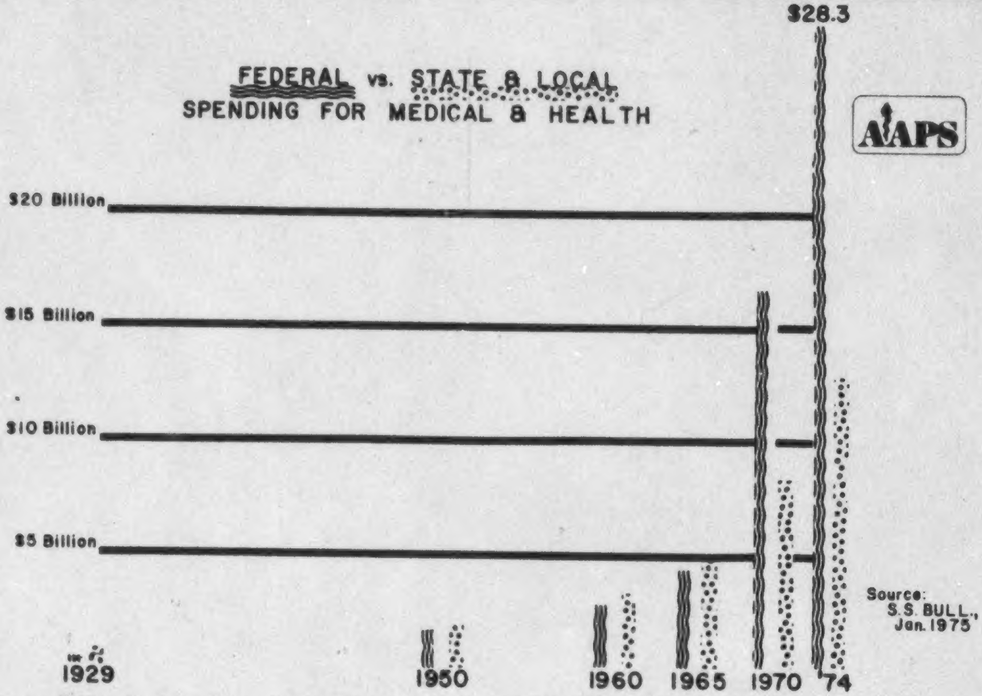
TOTAL PAYMENTS = $ 3.251

Source: U.S. Budget Special Analysis
Fiscal Year 1975, p. 148-149

"Out of the $97 billion spent by HEW in 1974, only 3.3% -- $3.251 billion -- was in Medicare and Medicaid payments to doctors."

-- AAPS testimony to Health Subcommitt
of House Commerce Committee, 11-13-

FEDERAL vs. STATE & LOCAL SPENDING FOR MEDICAL & HEALTH

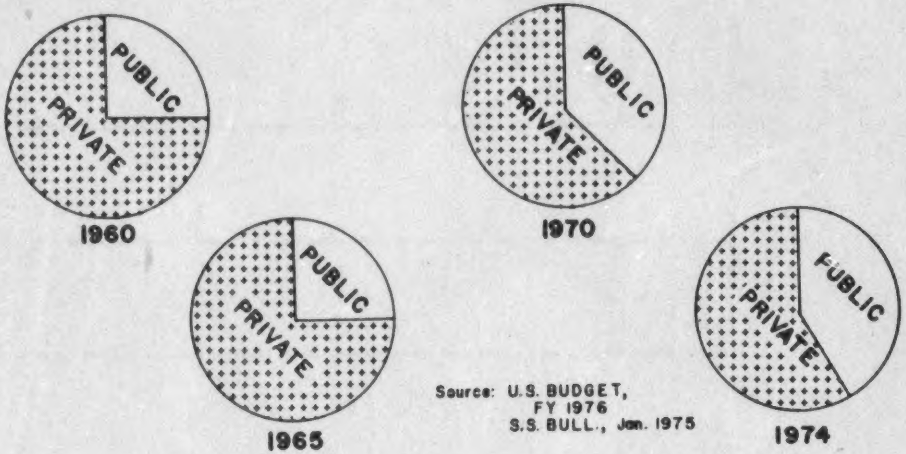


Source:
S.S. BULL.,
Jan. 1975

"This chart compares the medical and health spending by the federal government with that of state and local governments. In 1929, such federal spending was much less than state and local spending, and continued to be less in 1965. But in 1970 the comparison was much different, and in 1974 when HEW spent more than $28 billion, local and state governments spent less than half that amount. This is what happens when centralized government makes puppets out of local and state governments by the device of spend and spend, tax and tax, elect and elect."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

COMPARISON OF PUBLIC AND PRIVATE SPENDING FOR HEALTH



Source: U.S. BUDGET,
FY 1976
S.S. BULL., Jan. 1975

"This chart comparing public and private spending for health is based on data in the January, 1975, Social Security Bulletin which, by its comments appears to take pride in the fact that public spending for health which was about 25% of all spending in 1960, has now risen to become nearly half of all spending for health."

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

AAPS

H.E.W. vs FARM INCOME
vs CORPORATE PROFITS

	Billions
1. H.E.W. Spending 1974 actual	$100.875
2. Farm Income 1974 actual	29.100
3. All Corp. Profits After Taxes 1974 annual rate	69.900
	$99.000

H.E.W. Spending in 1974 was:

348% of all Farm Income

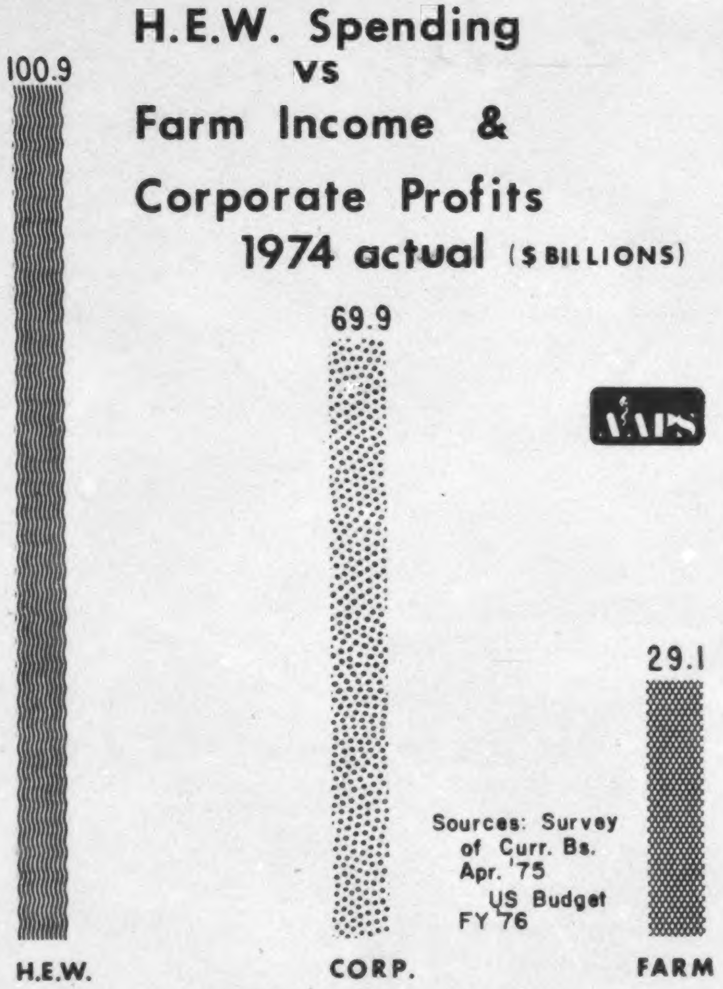
144% of all Net Profits of all Corporations

more than the combined Farm Income and Net Profits of all Corporations.

Sources:

1. U.S. Budget, FY 1976, p.56
2. Survey of Curr. Bs., April 1975, p.15, Table 7
3. Ibid. p.16, Table 10

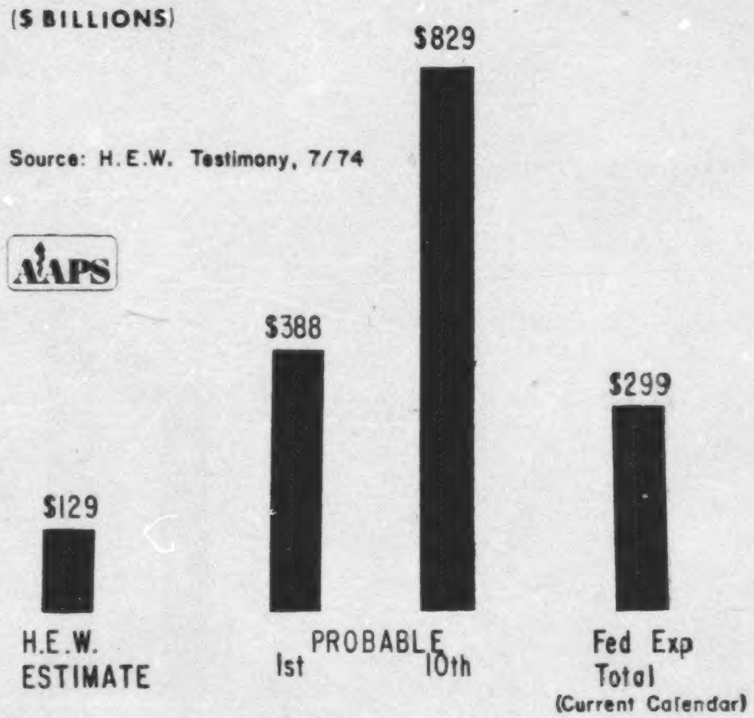
-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75



Sources: Survey of Curr. Bs. Apr. '75
US Budget FY 76

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

Cost of COMPULSORY POLITICAL Medicine for ALL (Kennedy—Corman)



Source: H.E.W. Testimony, 7/74

AAPS

— AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

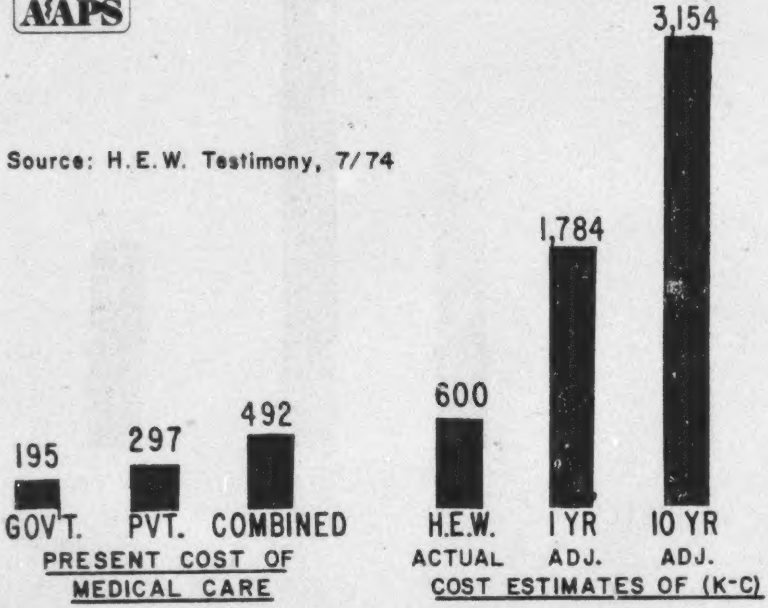
COMPULSORY POLITICAL MEDICINE

(*Kennedy – Corman*)

$ Cost per Person

(AVERAGE)

AAPS

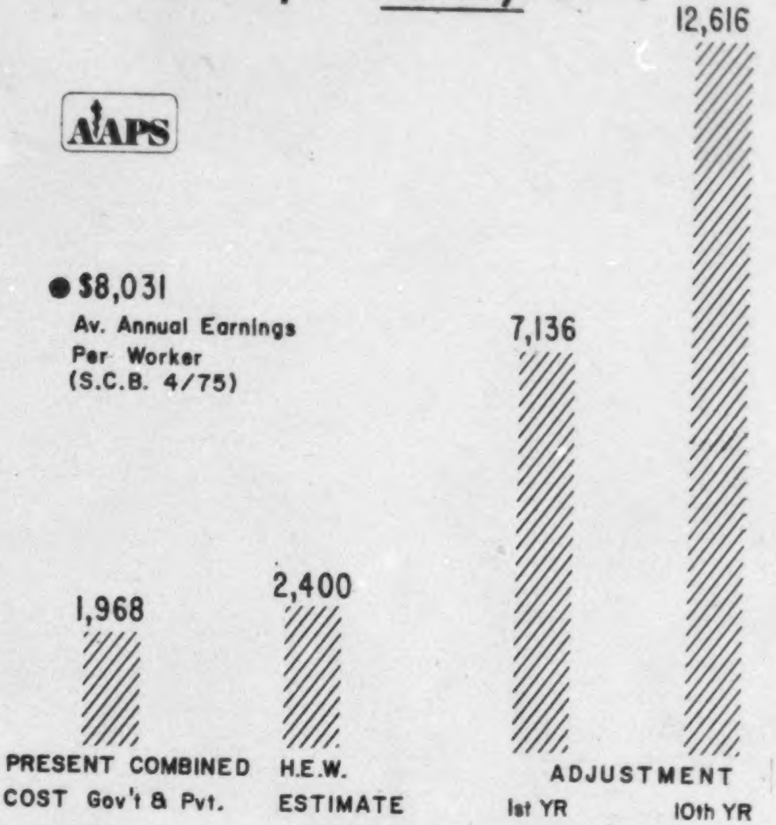


Source: H.E.W. Testimony, 7/74

-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

COMPULSORY POLITICAL MEDICINE

$ Cost per Family of 4



-- AAPS testimony to Health Subcommittee of House Commerce Committee, 11-13-75

Mr. ROGERS. Thank you very much, Doctor, for your testimony.

Dr. Carter.

Mr. CARTER. A very interesting presentation.

I thank you all.

Mr. ROGERS. Thank you so much for your presence here today. It has been most helpful.

This concludes the hearings and the committee stands adjourned.

[The following statements and letters were received for the record:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

TITLE I OF H.R. 8278, H.R. 5839, AND H.R. 3205

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association, which represents some 7,000 hospitals and other health care institutions located throughout the country.

I am glad to have this opportunity to place before your Health Subcommittee our Association's interest and concerns about legislation for establishment of a national strategy for health education and preventive medicine.

The American Hospital Association has long considered prevention of illness to be an essential element of optimum health services. This is reflected in numerous AHA policy statements. We have urged hospitals to continuously examine their programs and facilities in the light of their central role of coordinating health services to meet patient and community needs. We also have called for orientation of the health care delivery system to the maintenance of good health and the prevention of illness, in addition to treatment of injuries and of illness after it becomes acute. The Association's Board of Trustees last year voted to make hospital-based consumer health education a priority on the Association's agenda and approved a formal statement entitled "Health Education: Role and Responsibility of Health Care Institutions," copies of which have been provided to the Committee.

Health education encompasses the supplying of information to patients and to others, and basically is an effort to motivate all individuals to accept an active rather than a passive role in maintaining their own good health. Vast unmet needs in health education were identified in the 1973 Report of the President's Committee on Health Education, and there is an increasing awareness of the importance of health education on the part of health professionals and organizations. In addition, a number of individual hospitals and other health care institutions have developed both patient education and community health education programs. The hospital provides a unique opportunity to teach individuals more about their health than they knew before an episode of illness or an injury, and patients are most receptive and responsive to instruction on health matters during periods of hospitalization.

To emphasize the American Hospital Association's strong support of such health education efforts, I would like to quote portions of the Association's statement on Health Education: Role and Responsibility of Health Care Institutions:

"Health education is an integral part of high quality health care. Hospitals and other health care institutions, as focal points of community health care, have an obligation to promote, organize, implement, and evaluate health education programs. As a part of this process, hospitals should plan with other health care institutions and community agencies to define each organization's role and responsibility in meeting the health education needs of the populations it serves.

"In order to improve health and health care services, ongoing systems of health education must be planned, implemented, and documented. The maintenance of health and the prevention of disease can be achieved by a cooperative effort between knowledgeable and motivated consumers and health care personnel. Health education is a planned process that entails the joint identification of needs, the exchange of knowledge and concerns, and the clarification of personal responsibilities for health—all designed to encourage positive health practices and to improve the delivery of health care.

"The major emphasis of health education is health promotion, which includes health maintenance, disease and trauma management, and the improvement of the health care system and its utilization. Through health education programs, hospitals and other health care institutions can contribute to important health care goals, such as improved quality of patient care, better utilization of outpatient services, fewer admissions and readmissions to inpatient facilities, shorter lengths of stay, and reduced health care costs.

"A significant corporate commitment, including staff and financial resources, is essential if hospitals and other health care institutions are to fulfill their leadership role in health education. This commitment involves the acceptance and implementation of health education as an integral component of health care, the designation of specific responsibility for organizing and implementing health education programs, and continuing education. Programs to fulfill this commitment can be developed either independently by hospitals or other health care institutions, or through collaboration with health professional groups, consumer groups, health associations concerned with specific diseases, and the educational community.

"Financial responsibility for health education that is integral to the treatment and care of the patient is a legitimate part of the cost of caring for the patient. Health education that is designed to maintain the good health of the community at large and to prevent illness should be viewed as a service to the community. Such services are legitimate activities for hospitals and other health care institutions; however, efforts should be made to broaden the base of financial support for them by working collaboratively with other agencies and by seeking funding for health education programs."

The Association currently is engaged in a variety of programmatic efforts to encourage its member hospitals to implement organized patient education activities and to contribute as much as possible to community health education efforts. Additional staff has been employed to work in this effort, and at the Association's annual meeting this past August, five instructional sessions were conducted on health and patient education. Workshops for implementation of patient education have been sponsored by the Association on its own and in cooperation with other organizations.

The President's Committee

The report of the President's Committee on Health Education made two principal recommendations concerning the formation of organizations to promote health education. The first was that a focal point should be established in the Department of Health, Education and Welfare to coordinate and monitor the health education activities of the government.

In response to this recommendation, a Bureau of Health Education was established under existing authority as part of the U.S. Public Health Service's Center for Disease Control. The Bureau has been in existence for about a year but has had very limited funds and personnel for carrying out its responsibilities. It has, however, begun to coordinate the health education efforts of the various agencies of HEW and to establish liaison with other federal departments and agencies. Like the sponsors of the health education bills that have been introduced in both the House and the Senate, we want to see a stronger commitment to health education by the government, a commitment focused in HEW.

We strongly recommend funding and personnel to adequately handle the Bureau's program operations, with policy development and implementation at the department level which can deal meaningfully, not only with such activities in HEW, but throughout government wherever health and health-related concerns are at issue. It is vital that government act consistently in many basic aspects of health education, including such efforts as accident prevention, and programs to curb or eliminate smoking, obesity, alcoholism and drug abuse. Government must assume that its own activities in health and in programs that affect health are, in fact, not counterproductive.

The second major recommendation of the President's Committee on Health Education was that a nonprofit national center for health education should be developed in the private sector to stimulate, coordinate and evaluate health education programs and to be a source of innovative problem-solving and policy guides for health education activities. This recommendation is also in the process of being implemented. The National Health Council, under a contract funded by the Bureau of Health Education, has conducted a study over the past year of the feasibility and utility of establishment of a national center for health education in the private sector. The report of this study which was recently submitted calls for establishment of such a health education center as a private, nongovernmental, not-for-profit organization to serve as a national focal point for promoting, coordinating and upgrading programs to educate citizens on maintaining their own health and that of their families. As a direct result of the study and its recommendations, a number of voluntary health organizations have moved ahead cooperatively to establish the National Center for Health Education with headquarters initially located in New York. John Alexander McMahon, President of the American Hospital Association, is serving as a member of the Center's Board, and Fairleigh S. Dickinson, Jr., was elected chairman of the organization at the first meeting of the Board of Directors on October 1.

Many voluntary health organizations have been involved in health education for several years. They have brought together thousands of volunteer workers and contributors and have helped to assure a multiplicity of creative approaches to the problems of health education. Their contributions have been significant and they have been funded essentially with nongovernmental monies. We feel these efforts should be expanded rather than duplicated or discarded. There is, of course, a need for better coordinating such activities and directing them toward meeting defined national goals. To this end, the nongovernmental National Center for Health Education has been established.

Recognizing that the needs and problems in the areas of health information, health education, health promotion, and preventive health services are both enormous and complex, it is apparent to us that a long-term commitment by both the governmental and private sectors of society will be required. The American Hospital Association, therefore, supports fully the recommendation of the President's Committee and the report and recommendation of the National Health Council that there be two complementary national health education organizations, one governmental and one in the private sector.

The National Disease Control and Consumer Health Education and Promotion bill which the Senate passed on July 30 this year would deal with the establishment of an Office of Consumer Health Education and Promotion within the Department of HEW and would provide for establishment of the Center for Health Education and Promotion in the private sector. On the other hand, Title I of H.R. 8278 calls for establishment of a National Institute for Health Information, Education and Promotion, but does not include any provisions for a publicly-chartered health education center. The basic thrust of the Senate-passed bill, S. 1466, is, therefore, more in accord with the views of AHA than is Title I of H.R. 8278, and we strongly urge your Subcommittee to adopt the approach of the Senate-passed bill.

Having stated our preference for S. 1466, I would like to offer the following specific comments regarding some of the provisions of Title I of H.R. 8278. The principles these comments reflect would, of course, apply to the Subcommittee's consideration of H.R. 5839 and H.R. 3205.

1. The new Section 1703 that would be added to the Public Health Service Act if H.R. 8278 is enacted calls for establishment of standards to be met by institutional providers of health services to beneficiaries of government programs funded under the PHS Act and the Medicaid program. We would point out to the Committee that considerable work is needed to establish the most effective basic approaches to health education and their applicability in the variety of institutional settings that exist. We believe this work should be done before it would be appropriate to consider mandating standards to be implemented by all institutional providers of health care, large and small, and whether located in densely populated metropolitan areas or in rural areas.

Such activities by governmental agencies as are contemplated and authorized in the new Section 1703 to modify citizens' behavior, control mass media content and school curricula may well conflict with constitutionally guaranteed private freedoms. Scientifically sound, effective and culturally acceptable health education efforts involve extremely difficult issues, and heavy-handed government controls would, we believe, discourage rather than stimulate desirable health education programs. That is the primary reason why private action with volunteer support is so essential.

2. H.R. 8278 in the new Section 714 lists information activities which the proposed Institute for Health Information, Education, and Promotion would be authorized to conduct. These include the publication of a journal for health professionals, a journal for the general public, and the publication of information and pamphlets to interest and instruct the health consumer. Voluntary agencies, professional organizations, and commercial companies are but a few of the groups that are presently engaged in producing such materials. While it is an appropriate role for a national government organization to support a clearinghouse for health education information and to be a coordinating and catalytic

agent through grants and contracts, we feel it is inappropriate for a government organization to carry out activities which nongovernmental organizations are or can be performing.

3. There is need for grant and contract support by the government for organizing and implementing health education programs on a community and district or regional basis. Among the specific purposes of such project grants are:

The training of staffs of provider organizations and institutions to carry out health education.

Evaluation of the impact of health education programs on a defined geographic group.

Promotion of the sharing of expertise and resources among professionals, organizations, and institutions of a community and a region.

Enhancement of consistency of information to the consumer from health setting to health setting, as well as from health provider institutions and from other health organizations within a community and a region.

Maximum promotion of the utilization of potential consumer education through the media.

Enhancement of reinforcement and follow-up activities.

Under the provisions of the new Section 1713, grants and contracts for various health education, research, demonstration and evaluation activities could be made only to health education centers that are located within an established academic or research institution. We believe such support should not be restricted to academic and research institutions, and should in addition be made available to other qualified organizations under appropriate guidelines of the Secretary of HEW, including:

health education organizations not affiliated with academic or research institutions;

hospitals and ambulatory care centers;

health maintenance organizations;

health systems agencies; and

state hospital associations and other state, regional, and national organizations.

Mr. Chairman, you may be sure that the AHA will continue its active interest in promoting health education and preventive medicine. I must point out that such activities cost money and, as set forth in the Association's statement on "Health Education," we believe health education which is an integral part of the care of patients is a legitimate part of the cost of caring for patients. On the other hand, ~~health education~~ that is designed to maintain the good health of the community at large and to prevent illness should be viewed as a service to the community rather than an element of patient care.

The cost of hospital care is a matter of concern to hospitals as well as to patients and to the government, and hospitals are working hard to hold down costs without impairing the quality of care. One of the recommendations of the President's Committee was that "the government, prepayment plans and insurance carriers, which pay for health care services for others, be willing to adjust premium rates to include in their payments the cost of health education for the patients involved." Certainly, if any legislation is enacted to require hospitals to provide health education services, the legislation should also insure that providers of care will be reimbursed for such services. We strongly urge, therefore, that any such legislation that would require or permit any agency or department of the government to require health care institutions to provide health education services, the bill should also specifically provide for full payment to providers for such services.

Thank you for the opportunity to present the views and comments of the American Hospital Association on this important issue. If we can provide any further assistance to the Committee, we will be pleased to do so.

* * *

TITLE II OF H.R. 8278

I am pleased to express support of the legislation to extend the expiring vaccination and other communicable disease control authorities of Section 317 of the Public Health Service Act with expansion of the scope of the authority to include other diseases of national significance which are amenable to reduction. We also support legislation to strengthen and extend the venereal disease prevention and control program authorities of Section 318 of the PHS Act.

The American Hospital Association's long-standing commitment to prevention of illness is reflected in numerous policy statements including a "Statement on Optimum Health Services" approved in 1964. This statement declares prevention to be an essential element of optimum health services and urges hospitals to continuously examine their organization and facilities in the light of their central role in coordinating health services to meet patient and community needs. The Association's "Policy Statement on Provision of Health Services," 1971, calls for orientation of the health care delivery system to the maintenance of personal good health and to the prevention of illness in addition to the treatment of illness after it becomes acute.

The principal focus of the federal government's preventive health services is the U.S. Public Health Service's Center for Disease Control which is located in Atlanta, Georgia. The Center carries out a wide spectrum of program authorities related to stemming the spread of communicable diseases, including the communicable diseases (PHS Act Sec. 317) and venereal disease (PHS Act Sec. 318) control program authorities which expired on June 30, 1975. The outstanding competence and achievements of the National Center for Disease Control are well recognized and the Center deserves to be applauded, and the cooperative efforts of state and local governments working with the federal government in the areas of communicable disease and venereal disease control programs are an excellent example of the "partnership for health" concept.

Without attempting to review in detail the activities carried out under Sections 317 and 318 of the PHS Act, let me simply point to a significant example.

In 1966 there were some 200,000 reported cases of measles. As a result of programs the Public Health Service undertook, the number of cases of measles dropped to 20,000 in 1968. The authorization for those programs expired in 1969 and immediately the number of cases went up to almost 100,000. New authority was approved for vaccination assistance activities in 1971 and the next year the number of cases of measles went back down to about 20,000. If such vaccination assistance should again be halted, it is reasonable to expect a resurgence.

Medical knowledge and skill are available to greatly reduce or eliminate the serious threat that many communicable diseases, which affect millions of Americans each year and which can so quickly spread from one part of the country to another, pose to the health of our people, especially our children. Certainly the federal government's commitment to states and local governments for assistance in the prevention and control of such diseases must be maintained.

Extension and expansion of disease control authorities

Section 202 of Title II of H.R. 8278 would extend for three years the disease prevention and control authorities found in Sections 311 and 317 of the Public Health Service Act. It would also broaden the scope of the Section 317 authority to include prevention and control activities for certain non-communicable diseases of national significance including diabetes, hypertension, pulmonary disease and cardiovascular disease. Further, the bill would consolidate in Section 317 the programs aimed at control and prevention of diseases borne by rodents and lead poisoning, as well as the PHS Act authorities for dealing with health emergencies and epidemics. We support the extension and expansion of these authorities as being essential to continuation of a coordinated attack against disease and the consolidations seem to us desirable.

We have noted that while the bill amends Section 311 of the PHS Act to bring together the authorities found there and in Section 317 to deal with epidemics and other health emergencies, it appears that the annual authorization of $5 million in Section 317(e) was inadvertently omitted. Apparently this is only an oversight and we trust the authorization will be restored when your Subcommittee acts on the legislation.

We are pleased that H.R. 8278 would amend Section 317 to authorize grants to nonprofit entities as well as to state health authorities and public entities, and would also enlarge the present authority to include grants for demonstration and training with respect to disease prevention and control. These provisions would serve to strengthen the programs and we support them.

Extension and expansion of venereal disease prevention and control authorities

With regard to the provisions of H.R. 8278 that would extend for three years certain authorities in Section 318 of the PHS Act, "Projects and Programs for the Prevention and Control of Venereal Disease," we wish to offer the following recommendations.

1. In addition to syphilis and gonorrhea, other sexually transmitted diseases such as genital herpes and non-gonoccal urethritis are emerging public health problems which call for attention. To broaden the scope and flexibility of the attack on venereal disease we urge the Committee to include in the bill a provision specifically defining the term "venereal disease" to include in addition to syphilis and gonorrhea any other sexually transmitted disease which the Secretary finds to be of national significance and amenable to control. Such a provision is included in S. 1466, the National Disease Control and Consumer Health Education and Promotion bill which the Senate passed on July 30, and we hope that your Committee and the House will take similar action.

2. The annual appropriations authorization contained in H.R. 8278 for project grants to the states for venereal disease surveillance activities, case-finding and followup, venereal disease education activities, and studies and demonstrations to evaluate or test venereal disease control (Sec. 318(d)) is $30 million, which is the same amount the now-expired law authorized for FY 1975. Against the Section 318(d) authorization of $30 million for FY 1975, the program was funded at $28 million. Allowing only for an 8 percent inflation factor, without any provision for expansion of the program, would require appropriations of $30.2 million for FY 1976, $32.7 million for FY 1977, and $35.3 million for FY 1978. We support such authorization levels for the Section 318(d) program.

Summary

Mr. Chairman, the American Hospital Association agrees with you and the other members of your Health Subcommittee who joined in introducing H.R. 8278 that the disease prevention and control authorities in the Public Health Service Act must be extended. Further, we recommend the following amendments be made in Title II of H.R. 8278 to strengthen and improve the programs.

1. That the $5 million annual authorization for vaccination programs and other programs to meet epidemics and health emergencies be renewed.

2. That the term "venereal disease" be specifically defined in the bill to include in addition to syphilis and gonorrhea and other sexually transmitted disease which the Secretary of HEW finds to be of national significance and amenable to control.

3. That the bill's authorization for Section 318(d) be increased to at least $30.2 million for FY 1976, to $32.7 million for FY 1977, and to $35.3 million for FY 1978, which would reflect only an 8 per cent inflation factor.

Thank you for the opportunity to bring the views and concerns of the American Hospital Association with regard to disease prevention and control programs to the attention of your Subcommittee. If we can provide any additional information or assistance, we will be pleased to do so.

STATEMENT OF THE U.S. CATHOLIC CONFERENCE

In 1971 and again in 1973, in presenting testimony to your colleagues on the Ways and Means Committee on various national health insurance proposals, the U.S. Catholic Conference strongly emphasized the need for a health eduaction program as an essential component in any national preventative health care policy. It was then, and remains, our firm conviction that health maintenance education is crucial to achieving an acceptable standard of physical well-being for all of our nation's people. Preventative health maintenance is indispensable to ensure a maximum quality of life—physical, mental, social and economic—for each person and, without the knowledge to practice preventative health maintenance, it remains an elusive goal.

Personal responsibility for practicing good health habits will remain largely neglected unless there is a firm commitment by all segments of our nation's leadership to organize and stimulate continuing national health education programs. To create and sustain in each individual an awareness of the requirements of personal health maintenance and of family health habits will demand a sizable and continuing effort on the part of committed public, private, and governmental organizations. Such a commitment is intended in the legislation now being considered by this Subcommittee: H.R. 8278, H.R. 8995, H.R. 3205, and S. 1466.

When the U.S. Catholic Conference previously advocated a programatic approach by Congress toward a national health education policy, we supported an effort which would reach both the patient and the general public, the use of classroom situations in schools and in health care facilities, broad use of the media and research, publication and wide distribution of personal health education materials of professional and popular usefulness and acceptance. Most of the bills pending before the Subcommittee provide for some or all of those specific recommendations.

Important, too, is the fact that, besides the advantage of better heath provided by a national health education program, the demands on our health care institutions and personnel will be decreased, as will the total cost of securing adequate health care.

We would, however, offer a few observations on the health education proposals being considered by the Subcommittee which are important to the full participation of all educational and health care institutions, particularly those sponsored by churches and religious organizations.

Each of the bills gives the Secretary of the Department of Health, Education, and Welfare a broad mandate to fit within the administrative structure provided by Congress, health education programs of whatever substance he chooses.

Each funded participant must implement those programs proscribed by the Secretary. Without qualifying language, this creates a number of serious problems.

First, given no legislative safeguard, the language would enable the Secretary to discontinue certain funding for health care providers unable to implement aspects of the health education programs which are objectionable on moral, ethical, or religious grounds. Such regulations would have a similar discriminatory effect for individuals with particular religious convictions employed in nondenominational health care institutions. An obvious instance, in the case of Catholic health personnel and Catholic institutions, would be the representation of abortion and particular family planning methods as appropriate alternative health care measures. Objections to medical procedures tacitly condoned or sponsored by the Department of Health, Education, and Welfare are not unique among non-Catholic facilities.

Congress sought to avoid such situations in the delivery of health care with Section 401(b) of P.L. 93–45, the Health Programs Extension Act of 1973. That provision denied authorization to require an institution or an individual to perform any sterilization procedure or abortion if to do so were contrary to religious beliefs or moral convictions. However, the language of Section 401(b) is restricted to the *performance* of sterilization procedures and abortions and would not encompass a requirement to promulgate educational materials and information as proposed by H.R. 8995, H.R. 8278, H.R. 3205, and S. 1466.

Secondly, the same four health education bills would deny participation by private schools in national, federally-sponsored health education programs if certain content proscribed by the Secretary of the Department of Health, Education, and Welfare were contrary to ethical, moral, or religious beliefs. Individual personnel in a public school system may not have the freedom to decline participation in those aspects of health education programs which were objectionable to their ethical, moral, or religious convictions. Again, Catholic educational personnel and Catholic educational institutions would object to the representation of abortion and particular family planning methods as appropriate alternatives and, again, similar objections would not be unique among non-Catholic institutions and individuals.

In order for the U.S. Catholic Conference to support any national health education legislation drafted by this Subcommittee, it must include some form of a "conscience clause", similar to that which the Congress embodied in P.L. 93–45, to protect individuals and private health care and educational institutions from discrimination due to ethical, moral, or religious convictions. It is important that such a provision be broad enough to protect individuals and any organization or institution which may be construed as an "appropriate setting" to avoid any impact of religious or other form of discrimination.

A third problem arises with the broad mandate given the Secretary of Health, Education, and Welfare, in determining the content of the health education programs implemented in both public and private, non-profit elementary and secondary schools. There appears to be no voice given state and local school systems as to what shall be taught in health education programs. Also, there appears to be no discretion on the part of parents or guardians to withdraw their child or ward from those aspects of a health education curriculum which they believe conflict with the values they seek to instill in their family. The only alternative would be to relinquish one's beliefs or to withdraw the child from school, neither of which is consistent with the goals of our public school system, as advocated by Congress and the American people.

The ability to determine the curriculum in our public schools has been zealously protected by state and local governments throughout the history of Federal involvement in education. H.R. 8995, H.R. 8278, H.R. 3205, and S. 1466, by virtue of the broad authority given the Secretary of the Department of Health, Education, and Welfare, constitutes a rather dramatic change in public policy and one which would be greeted with a great deal of resistance from state and local school authorities and by concerned parents of school children.

Section 432 of P.L. 90-247, the General Education Provisions Act, states: "No provision of the Act of September 30, 1950, Public Law 874, Eighty-First Congress; the National Defense Education Act of 1958; the Act of September 23, 1950, Public Law 815, Eighty-First Congress; the Higher Education Facilities Act of 1963; the Elementary and Secondary Education Act of 1965; the Higher Education Act of 1965; the International Education Act of 1966; the Emergency School Aid Act; or the Vocational Education Act of 1963 shall be construed to authorize any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over the curriculum, program of instruction, administration, or personnel of any educational institution, school, or school system, or over the selection of library resources, textbooks, or other printed or published instructional materials by any educational institution or school system."

Section 432, titled "Prohibition Against Federal Control of Education", states clearly the convictions of Congress that the Secretary of the Department of Health, Education, and Welfare will not determine the content of education programs. It would be remarkably inconsistent for the Secretary to be prohibited from regulating course content as the chief administrator of federal educational programs, but be given the authority to delegate such control to his health administrators.

There must be incorporated into any proposed health education law, the freedom for parents to choose either to allow their children to participate in health education programs or not to participate in part or all of such programs. Furthermore, no legislation should fail to recognize the limits of Federal intervention contained in Section 432 of P.L. 90-247 and contravene our present national educational policy.

Fourthly, the proposed legislation should provide for the freedom of choice of any patients or members of the community to decline participation in any health education program, on their own behalf or on behalf of their children or wards. This is particularly important in those hospital settings when the ability of a patient to provide informed consent is questionable. An awareness of the potential problems created by an involuntary program is evidenced in Title II of H.R. 8278, in adding Section 317(i)(2) to the Disease Prevention and Control Act. Similar language must be included in a health education bill.

A fifth concern is the need to state clearly the inclusion of both "public and private, non-profit" institutions (educational, health care, and "appropriate settings") in health education programs. We would like to see the inclusion of such language in the final draft of the legislation and in the committee report.

The inclusion of private, non-profit institutions is made clear in the Senate Report and in several sections in the Senate and House bills; However, other sections in all of the bills could possibly be construed as excluding full participation by all segments of our health industry and educational system. This would seem to be contrary to the general language of all the bills, such as can be exemplified in Section 102(3) of H.R. 8995, in which the Secretary is to ". . . incorporate appropriate health education components into every facet of our society, especially into all aspects of health care and educational programming."

Lastly, we would like to concur with an important recommendation submitted by the American Hospital Association before this Subcommittee on November 12, 1975. An effective health education program, whether incorporated in various categorical programs or established as a separate element of a national preventative health care strategy, will require an added commitment of personnel and resources within our health institutions. We support the authorization of realistic Federal funding, in order to ensure the objectives envisioned by the Subcommittee are fully realized.

In closing, we would like to reiterate the major provisions which we believe must be included in any proposed national health education law:

(1) Conscience clause protection for religious individuals and institutional providers of health care, allowing full, non-discriminatory participation, such as found in Section 401(b) of P.L. 93-45;

(2) Similar conscience clause protection to allow full, non-discriminatory participation by religious educational institutions and educators;

(3) State and local control of the content of health education programs in secondary and elementary schools, as provided in section 432 of P.L. 90-247, and discretion for a parent or guardian to withdraw a child or ward from any part of/or an entire health education program;

(4) Ensuring that any participation on the part of a patient or member of the community is entirely voluntary;

(5) Eliminating the possibility of a discriminatory statute by specifically including "public and private, non-profit" institutions; and,

(6) A sufficient financial commitment by the Federal government to ensure substantive accomplishments in a national health education program.

Should the safeguards and commitment we have requested be incorporated in a national health education scheme, the United States Catholic Conference will offer any support and assistance possible for the accomplishments sought in the health education bills the Subcommittee is considering.

STATEMENT OF MARVIN BELSKY, M.D., FOR NEW DIMENSIONS IN COMPREHENSIVE HEALTH, INC.

Summary

Quality health care requires a secure economic basis and the best technology, coupled with availability to the greatest number of people. But quality care also depends on direct provider-patient communication and patient consumer assertiveness, motivation, and education. Proposals are offered to create incentives for providers to encourage individual consumer involvement in his or her own health maintenance and well being.

Presently, 94¢ out of every health dollar is spent on treatment, 4¢ on research and of the remaining 2¢ for disease prevention, only 4/10¢ goes toward health eduaction and none on patient consumer participation in care. The effect of this incredibly skewed emphasis toward disease treatment may be to increase the total social cost of health care by the expense of treating sickness which may have been prevented, treating diseases and infirmities whose course may have been of shorter duration, treating recurrent incidents of such diseases involving the cardio vascular system, the pulmonary system, diabetes and the like, which may be avoided by proper health maintenance by the patient.

Needless to say, the costs relating to loss of work and productivity to the individual and his or her family, to industry, agriculture and government are considerable when public policy gives only passing attention to disease prevention.

The physician and the projected expended health care system have significant roles to play as teachers and dispensers of good health behavior, considering that the number of physician visits in the United States are now running at the rate of 1 billion per year.

We believe incentives should be given to health care providers to encourage direct individual patient participation in health maintenance in an informed assertve manner with health care providers.

Many studies indicate at laest ⅓ to ½ of patients do not comply with doctor recommendations or drug regimens, at least in part or in whole, with resulting wasted diagnoses, wasted drugs, wasted x-rays and wasted opportunities for well being. This waste may be multiplied with the advent of broader health coverage if steps are not taken to more actively involve the patient in good health practices.

The delivery of medical care in the United States today is undergoing a process of fundamental reappraisal. New laws and new forms will undoubtedly come into being. All of us may soon be covered by National Health Insurance and we strongly concur in this trend. Health-maintenance organizations—known as HMOs—are gaining popularity. Doctors are increasingly undergoing periodic competency reviews by their peers. But all such new forms and procedures deal primarily with the economics and technology of medical care, not its humanity or capacity for partnership between doctor, other health provider and patient.

Quality medical care requires a secure economic basis and the very best technology. But qualify care very much depends on concerned, humanistic communication. Without it, the doctor is handicapped and the patient endangered. Quality health care depends on active consumer engagement in good health care practices.

Various health insurance plans as proposed concern themselves amongst other things with payment for treatment, broader access to medical services and health care, diffusion of technology and development of new techniques, peer accountability by physician and consumer input to health planning councils and advisory boards.

Regrettably not enough concern or attention has been given to the likely possibility that, with long awaited broader availability of health services, there will be increased depersonalized and uncommunicative care than at present. There has been and is little recognition that the patient as consumer must participate in the therapeutic process in his or her own health enterprise with the health care provider as the key to his or her own well being.

Presently, physicians are thought of by the public as someone to turn to when illness or disability occurs. The physician is highly regarded—even held in awe—as a healer. Doctors easily acquiesce in this role and their exceptional training and social status reinforce feelings or separateness. Insufficient emphasis is placed on the physician's role as a teacher. Nor is recognition given to the patient consumer as an individual who, given relevant information in a motivating way, can and will actively participate in his or her own health care and learn effective health behavior as a way of life.

A truly well-informed patient public which is expected to know and is encouraged to learn may well reduce malpractice, not directly associated with outright incompetence, because as consumers they will look for and get clear signals from the physician. Informed consent from a well informed patient in the context of a truly therapeutic relationship will enhance the total health care environment by reducing antagonistic roles.

In any new legislation, the patient as consumer will undoubtedly be represented at the macro-level on boards of health delivery systems and on advisory boards of governmental regulatory bodies. HMOs, hospitals, perhaps even PSROs, may have consumer representation, but any legislation must facilitate and integrate the individual patient consumer in an assertive, informed relationship with health care providers—be they doctors, nurses, or paramedical personnel or institutions such as hospitals.

Proposals

Health legislation or any national health insurance scheme enacted by Congress should encourage grass roots patient consumer participation by:

(a) underwriting or compensating through reimbursement patient education at the "teaching moment" in the health care facility or physicians' office by doctors, nurses, and professional health educators as part of a health care team. (More than 70% of present care is now provided by private practitioners.) Making available coverage for providing health education and motivation may reduce the total health bill compared to a system without it.

(b) underwriting or providing reimbursement to health care providers (be they institutions or private practitioners) for encouraging direct patient feedback mechanisms in small groups to heighten awareness of doctor-patient/provider-user roles and responsibilities and thereby increase patient motivation towards effective health behavior. A number of hospitals now increase their effectiveness by including a patient ombudsman on their staff to relate to patient complaints and to motivate patients in good health practices when they leave the hospital.

(c) underwriting or subsidizing the training of health educators and paramedical personnel to serve on the staff of hospitals, HMOs, group practices and perhaps with private practitioners.

(d) underwriting and supporting medical school curriculum changes designed to explore and reinforce the physician's role as teacher as well as healer and to encourage a more communicative relationship of the doctor to the individual patient, the community, and to other health care providers. There is now little encouragement for the medical student to increase his human relations skills as the overwhelming emphasis is on technology.

(e) underwriting and supporting studies to evaluate whether patient education at the individual and community level is effective, as opposed to the cost of benefits of operating a health care system without an important health education component. Consideration should be given to broken appointments, patient failure to follow advice, recurrence of illness that may have been averted or delayed and broader social costs, such as lost productivity and disruptions.

It is essential that we support a system which would emphasize well being, nutrition, exercise, disease prevention, and the health maintenance system—a system which would involve the patient consumer in a two-way therapeutic relationship with the physician, health educator and other health care providers.

As presently offered, many National Health Insurance proposals may aggravate the present alienating, deteriorating relationship of the health care system. We may only be buying technology over personal caring medicine without achieving maximum results for the dollars spent.

We urge concrete initiatives and incentives for providers to encourage patient consumer participation in their own well being and health maintenance.

STATEMENT OF THELMA KING THIEL, EXECUTIVE DIRECTOR, THE VENEREAL DISEASE SERVICE ORGANIZATION

Mr. Chairman and members of the subcommittee, I am presenting this statement on behalf on the Venereal Disease Service Organization, a private nonprofit organization, incorporated in 1971 in New Jersey, dedicated to the elimination of venereal disease through a comprehensive program of research, information, education and citizen action.

Funded with $20.00 seed money from HEW (directed through N.J. State Dept. of Health) 21 months ago, we have an impressive track record in reducing the venereal disease rates in our area of concentration. An evaluation done by the Center for Disease Control 6 months after our first funding found us to have one of the finest programs in the country.

Although we are an organization of state wide scope, we have concentrated our efforts in the Greater Newark area. The results have been dramatic with a drop in rate from No. 2 to No. 9 in the national gonorrhea statistics. In addition, New Jersey is the only state in the country that has demonstrated a continuous downward trend in the VD rate over the last 18 months. Almost 50% of the drop in the gonorrhea rate in New Jersey is related to the drop in Newark. About 80% of the drop in syphilis is also related to the drop in Newark, according to the New Jersey State Department of Health.

I am writing in support of HR 8278 Sec. 318(b)(1) that authorizes the "Secretary to make grants to States, political subdivisions of States, and any other public nonprofit private entity for projects for the conduct of research, demonstrations and training for the prevenion and control of venereal disease."

VDSO also supports Congressman Maguire's amendment that would add the words "and education" to this section.

With the emphasis being placed on preventive education in all health areas we feel that funds need to be granted directly to bonafide nonprofit organizations conducting VD education programs.

This year, funds which had been allocated for VDSO's continued education program were redirected by the State Department of Health to epidemiologic services because of fiscal problems in the state. Mr. Maguire's amendment would give the Secretary flexibility to grant funds directly to nonprofit organizations as well as through State Departments of Health whose priorities may be different.

We support the treatment and epidemiologic services as an essential part of VD control. Statistics from C.D.C. indicate that only 6% of patients treated for VD are treated through epidemiologic activities. However, 87% of all patients treated seek treatment voluntarily, directly related to education and awareness programs.

It is inconceivable that only 2% of VD control moneys are being spent on VD education programs related to 87% of patients.

Education is an effective weapon to prevent the spread of VD—but only when it is properly designed and operated. Recent surveys in California, Indiana and Pennsylvania show a reinfection rate of 27% among gonorrhea patients. The study concluded that "Methods are needed to education patients and obtain their active cooperation." To correlate VD education and gonorrhea incidence the report concluded that "after a period of increased school education efforts, 1970–73, teenage gonorrhea (15–19) decreased 28.2%, while the rest of the population showed only 12.7% decrease." (Los Angeles California) Sourse: American Social Health Assoc., 1974.)

We recommend that when appropriations are granted to nonprofit organizations a stipulation be made that successful programs, proved effective throughout the country, have continuity in federal funding to maintain and expand services.

In summary, the policy of C.D.C. to grant seed money to nonprofit organizations without a mechanism to evaluate and assure the continuity of a highly complex operation is a waste of tax dollars. We are confident that a partnership between the public and private sectors, which bring in private funds, is the most efficient and effective way of delivering health education to diverse groups.

Mr. Chairman, thank you for entering the statement of Venereal Disease Service Organization in the records.

STATEMENT OF MAXWELL M. GEFFEN, CHAIRMAN OF THE BOARD, FAMILY HEALTH MAGAZINE

Family Health Magazine respectfully submits the following views:—

(1) Family Health Magazine strongly supports the principle of legislation for a more comprehensive and coordinated Federal program to prevent disease through improved health information, education and promotion.

(2) Family Health urges that such legislation be designed to encourage and strengthen the efforts of the nation's private sector—its healing arts, pharmaceutical and food industries, not-for-profit organizations, like voluntary groups, Blue Cross/Blue Shield, plus private media—rather than discourage or preempt non-governmental efforts in health education.

(3) Family Health urges that the nation's media in particular be enlisted for health education. This would mean:

(*a*) strong media representation on a proposed Consumer Health Education and Promotion Advisory Council in DHEW;

(*b*) strong media liaison with the proposed Office of Consumer Health Education & Promotion in DHEW and

(*c*) strong media representation on the Board and Advisory Panel of a Center for Health Education & Promotion and continuing industry liaison with the Center's operations.

TWO BASIC QUESTIONS

Is new legislation for preventive medicine needed?

For the answer, we need only look at statistics—the grim toll of avoidable disease and disability—the needless heart attacks, the preventable lung cancer and emphysema, the unnecessary car accidents, widespread mental illness—alcoholism, drug abuse, suicide.

Is present Federal funding appropriate?

How could it be when out of the nation's total annual expenditure of $120 billion for health care, only an estimated 4% will go for prevention and education.

This ratio of 4% before-the-fact of illness to 96% after-the-fact is dismally out of balance.

With so little spent on prevention, the tendency is for human-made illness and disability to multiply faster than curative or restorative medicine can cope with. The only answer is for health leadership to do a better job in alerting the public to prevent illness and injury from occurring in the first place.

ROLE OF MAGAZINE INDUSTRY

For this purpose, the nation's private enterprise sector and in particular its media can play a much greater role.

Family Health does not presume to speak for all media, even for the magazine industry, alone.

But since we are a part of the magazine industry, we do believe that we can appropriately point out its particular role, especially the role of a health magazine or a general magazine with health interest.

Family Health is, it should be noted, the nation's most widely read, authoritative health magazine. Each month, our one million copies are read by over 4 million people.

EXAMPLES OF HEALTH INITIATIVES

Let me cite four instances of *Family Health* initiative. I cite these instances as illustrations of what can be done by and in the private sector. In all four, it was we who approached the Agency or healing art organization; it was not an outside source which initiated the plan; we told them what we were going to do, invited and received their cooperation and proceeded to do the communication job.

THE HEALTH INFORMATION NEED	HOW WE MET THE NEED
1. Pregnant women and new mothers have a special information need. Experts are agreed that preventive medicine pays the biggest dividends if commenced at the very start of life. The health of the pregnant woman and of the unborn fetus will shape the life of the child, the youth and the adult in more significant ways than virtually anything that may occur at a later time in life.	*Family Health's* October, 1975 issue had a special section devoted to maternal and infant health. The Section was produced under the direction of Dr. Michael Newton, former director of the American College of Obstetrics & Gynecology. Copies of the magazine were distributed with our compliments among members of the American College for reference by vast numbers of patients in waiting rooms. This is but one of many specialized issues and sections which we anticipate will link and reinforce the physician and the patient through our magazine.
2. 23 million Americans have high blood pressure. Only perhaps 1/10th are receiving adequate treatment for it. Millions of afflicted Americans do not realize their danger in not attending to the problem.	In May, 1975 at *Family Health's* initiative, an entire series of efforts were made in conjunction with National High Blood Pressure Month. At *Family Health's* request to the National High Blood Pressure Campaign, an article—by Harriet P. Dustan, M.D. on "What Every Woman Should Know About High Blood Pressure"—was prepared and we published it. An advertisement on the Campaign was prepared by the National High Blood Pressure Education Program and likewise printed in the same issue of our magazine. Most important, a special questionnaire on high blood pressure (Exhibit A) [not printed] was developed and printed on a card in the magazine. The questionnaire was filled in by readers and the card was mailed back to *Family Health* for tabulation and analysis. Through the article, ad and questionnaire, the public gained greater knowledge about high blood pressure and communicated what it wanted to know further; the feedback enabled the magazine and the Federal agency to become more aware of the public's knowledge, practice and attitude on high blood pressure. Meanwhile, the article has been extensively reprinted.
3. Survey after survey has shown that Americans are under-informed about nutrition. Low income Americans do not have an adequate diet—not only because they cannot afford it but because they don't know enough about good nutrition. And millions of Americans with more adequate income are nonetheless mis-nourished and under-informed.	*Family Health* at its own initiative invited the Advertising Council, the U.S. Department of Health, Education & Welfare and the U.S. Department of Agriculture to cooperate with us in reprinting the Council's informative 32 page booklet, "Food Is More Than Just Something To Eat." We reprinted the full text in all 1 million of our issues—at far lower expense than could have been achieved by any other manner of distribution. We did not make one penny on the reprint; it was done entirely at out-of-pocket cost through the public service cooperation of one of our food advertisers.

4. Sick, injured and troubled people often do not know where to turn to for help even though there are scores of national, state and local voluntary health organizations and other sources—private and public—eager to assist. There is need therefore for many directory-type resources whereby people in need could learn where they can find help.

Family Health has published directory-type articles such as "An A-To-Z Directory—Useful Information for Older People." We reprinted one such, "Where to Find Health Help," listing major health organizations, public and private, serving people of all ages, and the literature they publish. This booklet—Exhibit B [not printed]—was very well received and is the type of directory which should be made available by a national health education program.

Additional illustrations could be cited; each represents an area where a private enterprise magazine performs an information service which might otherwise have to be performed by Government.

Family Health seeks, however, to maximize the contribution we can make; limited.

What Family Health has done and is doing is to meet just a part of the vast need of the American public for health information.

THE NEED FOR PARTNERSHIP

Family Health seeks, however, to maximize the contribution we can made; that is why we urge the Congress to write into the pending legislation a mandate for Federal-private cooperation.

The Department of Health, Education and Welfare should implement the law which Congress writes by exercising DHEW's imagination, its creativity and above all its sense of partnership with the private sector. Let there be practical conferences, workshops, seminars in which Federal, State and local health officers, the healing arts and the media work out dynamic solutions to health information and education problems.

How can we together successfully motivate people to modify their self-destructive behavior?

How can we get people with dangerous symptoms to consult a physician promptly rather than too late?

How can we improve the often dismal record in which patients fail to take prescribed medication or otherwise ignore physician's advice?

These are but a few of many questions to which we must find solutions if this legislation is to come alive.

THE ROLE OF MAGAZINES IN FOSTERING HEALTH

Are magazines important in health communication?

The answer is, "Yes."

A 1971 Harris Poll commissioned by the Blue Cross Association found that as much as 26% of the American people get most of their health and medical information from magazines. This was 1% more than get such information from TV Medical News, 3% less than get the information from TV advertising and 2% less than from newspaper medical columns.

The media as sources of information were exceeded only by doctors who were named by 51% of the people as their source for health and medical information.

A Task Force of the National Conference on Preventive Medicine called for the establishment of a Council on TV and Consumer Health Education "to resume leadership in developing a long range industry wide plan for health education programing." The Task Force stressed TV, but stated:

"Our emphasis on TV is by no means intended to belittle the influence of the press, radio and other media which have also produced some excellent material and whose continuing participation should be enlisted in the national effort to improve consumer health education."

Let me note that unlike TV programs go on and off, a magazine—like a book—is a permanent reference source. It is there when you need it—at your convenience, to be re-read, to be passed along to others, to be consulted for exact meaning (rather than trying to recall it via a dim memory.)

In addition, unlike TV, a magazine can promote general health awareness. A reader is apprised not just on one subject—as on the usual TV program like Marcus Welby M.D.—but on a multiplicity of health topics.

A magazine is a distribution system into millions of mailboxes and homes: thanks to the miracles of printing and computer science, it can target special pages and inserts to particular geographic or other audiences.

But all media have their respective advantages and Family Health urges that each be encouraged to do its best for good health.

IMPORTANT ROLE OF THE ADVERTISING INDUSTRY

On a related phase, Family Health strongly recommends that Federal Agencies, notably DHEW do more to enlist the cooperation of the advertising industry.

This industry possesses skills in communication surpassing those of any such industry in the world.

Its public interest—and that of its clients—has been demonstrated in countless public service campaigns conducted by the Advertising Council and in other not-for-profit projects.

The advertising industry spends over $26 billion annually on behalf of its clients.

It would be difficult to overestimate what this industry could further do if it and its clients were voluntarily enlisted to improve health. The food industry alone through its vast advertising expenditures can play an immensely valuable role. Already, many of its ads perform admirably—getting across a health message.

Each year, Family Health confers awards for excellence in Nutrition Advertising in all media. Our awards are made both to the client companies and their advertising agencies. The awards are impartially administered by the Society for Nutrition Education. The awards jury is comprised of representatives of the American Institute of Nutrition, American Home Economics Association, American Dietetic Association, the Society for Nutrition Education as well as consumer and advertising representatives. In 1975, we are glad to report there have been more entries for the awards than ever before.

CONCLUSION

Congress can and should give the Executive Branch a mandate not only to strengthen preventive medicine but to do so by maximum encouragement to and utilization of the nation's existing resources. There is no need for any Agency to "reinvent the communications wheel."

Only by voluntary partnership of public and private resources can the nation be confident that the legislation now pending before this Committee will achieve its worthy goals.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., October 29, 1975.

Hon. PAUL ROGERS,
Chairman, Subcommittee on Health and Environment, House Interstate and Foreign Commerce Committee, Washington, D.C.

DEAR MR. CHAIRMAN: I am enclosing a copy of a letter I have received from Dr. Donald Manson of the Department of Public Health for the City of Akron, Ohio urging extension of the lead paint poisoning prevention program. I understand that your subcommittee will begin hearings on this program in connection with the National Health Education Act next week and would appreciate it if Dr. Manson's letter is included in the hearing record. Thank you.

Sincerely,

JOHN F. SEIBERLING, M.C.

Enclosure.

THE CITY OF AKRON OHIO,
DEPARTMENT OF PUBLIC HEALTH,
Akron, October 21, 1975.

Congressman JOHN SEIBERLING,
Longworth House Office Building,
Washington, D.C.

DEAR CONGRESSMAN SEIBERLING: I understand that Senate bill (S 1664) will soon be acted upon by the House. This bill extends authorization for appropriations for lead-based paint poisoning prevention, regulates the amount of lead allowable in paint, places with title I of the Act an increased emphasis on abatement as a necessary part of the medical treatment process and establishes an authorization for 1976.

I am writing to ask for your support in the House regarding the extension of authorizing legislation. We, in Akron, are initiating a Lead Poisoning Prevention Program. In our preliminary studies we have found as high as 24% elevated blood lead levels with a 12% confirmed in our sample population. We feel that is a significant percentage to warrant immediate attention and we are in the process of applying for federal funds for the prevention and treatment of childhood lead poisoning.

Without the assistance of federal funds we will not be able to supply the needed screening equipment and facilities or initiate as extensive a program for lead abatement. We realize that with the projected decrease in future funding that the City of Akron will quite possibly not receive adequate funds to initiate and follow through with a Lead Poison Prevention Program.

Now that we have identified a very serious childhood health hazard in Akron, I respectfully urge you to help make it possible for us to continue our efforts to provide the children of our city with a health program that will allow them to lead full and productive lives.

Sincerely,

DONALD J. MANSON, *Epidemiologist.*

THE UNIVERSITY OF CONNECTICUT, SCHOOL OF MEDICINE,
Farmington, Conn., October 30, 1975.

PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, Rayburn House Office Building, Washington, D.C.

DEAR CHAIRMAN ROGERS: Representative Ronald Sarasin (5th District, Connecticut) has forwarded material to you which represents findings of several colleagues and myself in regard to lead poisoning in the pediatric age group. All of this relates to standards which will be adopted for content of lead in paint.

I am writing again to you to emphasize a pediatric point of view in this very complex problem.

As you know, we all take in lead daily through air, atmospheric fall-out and via the food and water chain which indirectly reflects atmospheric lead. This lead results from industrial sources and atmospheric pollution with tetraethyl lead from automobile exhausts. Although serious poisoning rarely results from these sources, there is no question that they contribute a significant burden to man and eliminate a "margin of safety" in the growing toddler in an urban, heavily leaded environment.

The problem of lead in paint is also very complex. There are thousands of children in the U.S. who are carrying an excessive body burden of lead due to ingestion of old leaded paint. The effects of sub-clinical excess lead burden is still not defined, but evidence is accumulating which indicates that learning disabilities and coordination deficiencies may result. Lead is a very toxic and potentially lethal substance when ingested.

Today, we are seeing the result of decades of use of heavily leaded paint in dwelling units on surfaces accessible to young children. We have found paint with 33% lead content on porches and window sills not only in urban Hartford, CT, but in rural areas such as Dutchess County, NY. Lead poisoning occurs in both places. The common denominator is old housing (built prior to 1940) and curious youngsters. When repairs are not made and paint flakes, the hazard to children is greater because leaded paint is more accessible. Although we hear most about the urban areas, lead poisoning occurs wherever there is leaded paint accessible to young children. Paint is many layers thick on these surfaces. It is also difficult to remove it safely since leaded dust inhaled can poison, too.

For the sake of future generations, all lead must be eliminated from paint now. The nearly 10-fold difference between 0.5% and 0.06% lead in paint today translated to multiple layers of paint on a surface 30 years from now may represent the difference between a safe or unsafe surface for a child to explore with mouth and teeth. We must prevent contamination today that will affect our children and grandchildren.

I urge you and the committee to see that lead is eliminated from paint. Whatever standard is employed by the federal government now will affect housing codes nationwide. Thus, we can also help children today by making sure that their parents are not forced to rent apartments that are heavily leaded and that something can be done to assure this.

There are many voices representing the lead industries and paint producers. I am speaking for my young patients.

Thank you for your consideration of this matter.

Sincerely,

MARTHA L. LEPOW, M.D.,
Professor, Department of Pediatrics.

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS,
Washington, D.C., November 6, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: It is the purpose of this letter to advise you and your Subcommittee of the support of the Association of State and Territorial Health Officials of the purposes contained in Title II of H.R. 8278. The cooperative support of the Federal government to State and local efforts to control tuberculosis, venereal diseases, poliomyelitis, measles, rubella and other communicable diseases dating back, in some instances, to 1936 has been a most prudent investment of Federal health funds. Tens of thousands of lives have been saved and untold misery and disability spared from the ravages of tuberculosis alone over the past quarter century through the advent of chemotherapy and the vigorous application of control measures stimulated by Federal support grants. Again, the combination of an effective vaccine plus vigorous application to the susceptible population has resulted in the near extinction of poliomyelitis from our population. Similar successs have resulted from cooperative Federal-State-local efforts in relation to rubella and measles and tetanus and whooping cough. A similar success has not, however, been the experience in respect to venereal diseases, due in no small part, we believe, to the reduced level of support for VD control programs on the part of the Federal government. And here rests a lesson which should be given due consideration. Unfortunate though it may be, in all too many instances when the Federal interest, as manifested through financial support is diminished, State and local support is also reduced.

There is, in relation to rat control and lead-based paint control programs, greatly increased activity and favorable results because of the Federal initiative. The record clearly indicates the need for continued support as proposed in Title II of H.R. 8278.

We would draw to the attention of the Committee some features of the legislation which we find objectionable or which we question. We believe the reduction of the authorizations for preventive health programs (exclusive of venereal diseases) to be inappropriate. Decreasing appropriations for immunization program support is resulting in immunization levels for polio and measles, for instance, which are rapidly approaching, if they have not already reached, the danger level. Should this trend continue, we shall surely have at best sporadic outbreaks of totally unnecessary communicable diseases. We question, too, complete reliance upon project grants for immunization programs. With a predictable population to be served, this is a support program totally amenable to formula grant distribution of available funding with, of course, stipulated safeguards as to proper use.

We would point out, too, that insofar as we are able to ascertain the language on page 28, lines 15 through 23 is no longer pertinent and because of the possibility of its misinterpretation we would suggest deletion of Subsection 317 (g) (3).

Finally, we would remind the Committee of our serious problem relative to control of venereal diseases. It is useless to argue about the changes in mores and sociological factors which have contributed to the mercurial rise in the gonorrhea rates—they are with us. We believe the level of Federal financial support to State and local programs woefully insufficient and urge your considered attention to this matter. We further question elimination of authority for formula grants for these purposes (page 31, line 18). The fact that the Administration has not seen fit to request funds under this authority in the past is not persuasive and we recommend continuation of this authority.

Thank you for the consideration of the views of our organization. I would appreciate your making them a part of your hearing record.

Yours truly,

E. KENNETH AYCOCK, M.D., *President.*

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., November 17, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: The American Dental Association is concerned that the Subcommittee on Public Health and Environment in its current consideration of various Health Education and Disease Control bills, (H.R. 8278, H.R. 5839, and H.R. 3205) apparently has not included S. 1466 as passed by the Senate on July 30, 1975.

The bill contains the provisions of the Children's Dental Health Act (S. 2026) which we believe are wholly germane to the other bills before the Subcommittee and should be included in any bill reported to the full Committee and the House of Representatives.

As indicated in the attached statement, the dental health sections of the bill include four major provisions: (1) a specific program for dental health education concentrated on elementary and secondary school children; (2) a badly needed supplement to the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) for poor children covered by Medicaid; (3) a small-scale, voluntary matching grant program to assist communities working to initiate water treatment programs and (4) establishment of a Dental Advisory Committee to the Secretary of Health, Education and Welfare.

We will appreciate your consideration of this matter and request that this letter and accompanying statement be included as a part of the hearing record.

Sincerely yours,

PAUL W. KUNKEL, Jr., D.M.D.,
Chairman, Council on Legislation.

Enclosure.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association is pleased to have this opportunity to comment on H.R. 8278, the National Health Information, Education and Promotion Act of 1975; H.R. 5839, the National Health Education and Promotion Act; H.R. 3205, the National Health Education Policy and Development Act; and S. 1466, the National Disease Control and Consumer Health Education Act of 1975. Of major interest to the Association is the fact that the provisions of the Children's Dental Health Act (S. 2026) proposed by Senator Warren G. Magnuson (D-Wash.) have been included in S. 1466. As passed by the Senate, and referred by the Speaker to this Committee, these provisions are directly related to and are complementary to the other bills now before the subcommittee. Our statement will be directed primarily to those provisions.

The American Dental Association strongly supports the concept of health education of our citizens as well as the concept of training and knowledge in preventive health measures as sound bases for improving the health of the people of our nation.

Although the results of good health education and prevention programs can be dramatically shown, these elements of health care have not been utilized in the past in a way which approaches their fullest potential. Accordingly, the American Dental Association very strongly supports the basic concepts outlined in the bills before the subcommittee. These are measures designed to increase the availability of health education and disease prevention techniques for the people of the United States and the authors should be commended for their efforts in this field.

We would like to call particular attention to an issue which is of major importance to the dental profession. This is the development of a more meaningful and effective national effort of dental health education and oral disease prevention for children. We strongly believe that health education programs as well as preventive health programs can be most effective when applied to children. We have long supported such programs. Preventive health measures for children can increase the likelihood of good health throughout their lives; the same is true of health education measures. Therefore, we think it is particularly important that emphasis be placed on health education for elementary and secondary school children.

The Children's Dental Health Act, as it is contained in S. 1466, authorizes a broad based dental health education program for elementary and secondary school children. It also authorizes support for one of the most effective and safe disease prevention measures known to man, fluoridation of our drinking water. Finally, it authorizes support in the form of start-up assistance for the potentially very beneficial Early and Periodic Screening, Diagnosis, and Treatment program for children under Title XIX of the Social Security Act. We believe that the provisions of the Children's Dental Health Act offer specifically targeted preventive and health education programs and that they should be included as part of any disease control and health education measure approved by the subcommittee.

The fluoridation authority of the Children's Dental Health Act is contained in title III of S. 1466 as a proposed new section 1718 of the Public Health Service Act. Title IV of S. 1466 consists of the remaining Children's Dental Health Act provisions which also would be added as amendments to the Public Health Service Act.

The fluoridation provision of the Children's Dental Health Act authorizes a small amount of federal matching funds which would be available on a strictly voluntary basis to communities which decide to implement water treatment programs, to include those which would fluoridate community or school water systems. Although there has been resistance from a small and vocal but uninformed group of citizens concerning the use of fluorides, the benefits from and the safety of the controlled use of fluorides in preventing tooth decay are fully documented by extensive scientific evidence compiled over many, many years. Documentation is available from many reputable public and private sources. Attached (Appendix A) is a listing of the organizations which have endorsed the safety and effectiveness of fluoridation. The Department of HEW, in its Forward Plan for Health, fiscal years 1977–81, offers three options for a "special focus on preventing dental disease in children." (page 229). The first of these options is to promote the maintenance of optimal fluoride levels by supporting the installation and initial operating costs of fluoridation of community and school water supplies. This is the purpose of these provisions of the Children's Dental Health Act. We feel they would make a significant and constructive addition to any disease prevention and health education legislation.

The 1967 amendments to the Social Security Act included a provision under Title XIX that children, up to the age of 21, of Medicaid eligible families are entitled to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Dental care is a significant component of these services. Unfortunately, and for a variety of reasons, the EPSDT provisions of the Medicaid law have not yet been implemented on any significant basis. As Senator Magnuson pointed out during the discussion of S. 1466, "the implementation of the EPSDT program by the Department of HEW has been characterized by lack of enthusiasm, indifference, and foot dragging. The program languished for more than two years until a lawsuit was brought forcing the Department to carry out the provisions of the law." Even following this lawsuit, implementation has not been satisfactory.

The Children's Dental Health Act would authorize funds to state Medicaid agencies to be used to assist in carrying out needed comprehensive projects for dental care and services for children. This authority coincides with the second recommendation of the Department of HEW in its Forward Plan as it relates to dental care for children, which is to encourage the expansion of the dental component of the EPSDT program.

It is the intent of these provisions of the bill, which are included in title IV of S. 1466, to provide funds to enable state agencies to establish EPSDT projects. These funds are not to supplant those required from the Medicaid program, but will assist in getting Medicaid's special dental program for children underway. In the dental field, early prevention has been proven to be the single most significant element in assuring long-term good oral health. The benefits of providing early oral health care as contemplated under the EPSDT program and as assisted under these provisions of the Children's Dental Health Act will be enormous. We believe this authority should be included as an element in any health education and disease prevention program.

The third HEW option is to promote public visibility for, and professional awareness of, recently developed dental health education and preventive care practices. This is authorized by provisions in title IV of S. 1466, which would provide federal grants and contracts to support demonstration projects with respect to dental health education and dental health problems. Although the bills before the subcommittee address the question of health education, we feel that the provisions of S. 1466 are significant in that they place an appropriate emphasis on dental health education and more importantly that they emphasize that health education can most effectively be carried out at the elementary and secondary school levels.

In this connection we recommend that the general health education authority as contained in the bills before the subcommittee be strengthened with regard to programs for elementary and secondary school children. Just as preventive measures are most effective when provided to children so also will health education measures be most effective when begun at an early age. The provisions of the Children's Dental Health Act will enable children to utilize proper oral health practices throughout their lives. We would commend to you the approach taken in the Children's Dental Health Act with regard to health education, particularly its primary emphasis on the teaching of school children.

The fourth major section of the Children's Dental Health Act would establish a Dental Advisory Committee to be appointed by the President. This seven member committee, four of whom would be selected from the dental profession, would advise the Secretary of HEW with regard to activities carried on by the Department which relate to dental health, dental manpower, or dental training and services. The Dental Advisory Committee would be active in the areas of oral disease control and prevention. In addition, such a committee would help provide a significant focal point for the scattered dental health activities of HEW.

The implementation of the above described provisions will not result in major federal expenditures. In fact, their implementation will result, in the long run, in reduced federal and private expenditures as a result of an effective program of Early and Periodic Screening, Diagnosis, and Treatment, fluoridation and dental health education. We would strongly urge that the provisions of the Children's Dental Health Act as contained in S. 1466 be included in the bill which the subcommittee finally develops.

In conclusion, the American Dental Association strongly supports efforts to improve the health education of the American people. The bills before the subcommittee are intended to do just that and the authors are to be commended for their efforts. We do feel however, that the legislation reported out of Committee would be strengthened by including the provisions of the Children's Dental Health Act as has been done in the case of S. 1466.

APPENDIX A

NATIONAL ORGANIZATIONS ENDORSING FLUORIDATION [1]

American Dental Association.
American Academy of Pediatrics.
American Association for the Advancement of Science.
American Association of Dental Schools.
American Association of Industrial Dentists.
American Association of Public Health Dentists.
American College of Dentists.
American Dental Health Association.
American Dental Hygienists' Association.
American Federation of Labor and Congress of Industrial Organizations.
American Heart Association.
American Hospital Association.
American Institute of Nutrition.
American Legion.
American Medical Association.
American Nurses Association.
American Osteopathic Association.
American Pharmaceutical Association.
American Public Health Association.
American Public Welfare Association.
American School Health Association.
American Society of Dentistry for Children.

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[1] Source: U.S. Department of Health, Education and Welfare, Public Health Service, Division of Dentistry.

American Veterinary Medical Association.
American Water Works Association.
Association of Public Health Veterinarians.
Association of States & Territorial Health Officers.
Canadian Dental Association.
Canadian Medical Association.
College of American Pathologists.
Consumer Federation of America.
Federation of American Societies for Experimental Biology
Federation Dentaire Internationale.
Great Britain Ministry of Health.
Health Insurance Association of America.
Health League of Canada.
Inter-Association Committee on Health.
National Commission on Community Health Services.
National Congress of Parents and Teachers.
National Education Association.
National Health Council.
National Institute of Municipal Law Officers.
National Research Council.
Office of Civil Defense.
Pan American Health Organization.
Society of Toxicology.
U.S. Department of Agriculture.
U.S. Department of Defense.
U.S. Department of Health, Education and Welfare.
U.S. Environmental Protection Agency.
U.S. Junior Chamber of Commerce.
World Health Organization.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., December 2, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR MR. ROGERS: The American Medical Association would like to take this opportunity to offer its views on HR 8278—National Health Education and Disease Prevention Act of 1975 which was recently the subject of public hearings before your Subcommittee. We are in strong support of health education as a positive step toward continued good health. However, for the reasons which we will set out, we cannot support Title I of this legislation. With regard to Title II, we are in favor of a continuation of the present communicable disease prevention and control programs and would urge the Subcommittee's support of an extension of this important activity.

From its very beginning, the AMA has advocated health education of the public. Since that time, a substantial portion of the AMA's activities, funding and priorities have been directed toward health education. Organized medicine has endeavored to help the American people to help themselves to a more healthful life. While much remains to be accomplished in health education, a substantial amount of progress has been made in giving people the knowledge and means to exercise greater control over the condition of their health.

The National Health Education and Disease Prevention Act of 1975, HR 8278, would add a Title XVII to the Public Health Service Act under which would be created a National Institute for Health Information, Education and Promotion in HEW. It would be through this National Institute that the Secretary would discharge his responsibilities as enumerated in Title I of this legislation.

Although the intents and purposes of this legislation are desirable and deserving of support, we believe that activities already underway will accomplish the desired goals without establishing a new multi-layered agency within HEW and without the undertaking of the broad program contemplated by HR 8278.

On the Federal level, a Bureau of Health Education has already been established within the Center for Disease Control at the Public Health Service Facility in Atlanta. While this is a very new activity, it is already reported to be effective in improving communications and minimizing duplication among governmental health education programs. The Bureau is also participating in, and promoting, community health education programs at state and local levels through health departments and through cooperative efforts with local groups.

The Intra-Department Health Education Panel at the Assistant Secretary level was reactivated in HEW and is further reducing duplication of health education programs and activities within HEW. A contract was given to the National Health Council Inc. to carry out a study to determine the feasibility and usefulness of establishing a non-profit corporation, the National Center for Health Education. Based upon the favorable recommendations of the National Health Council, a Board of Trustees for this new National Center has been named and has already held one meeting.

At the state and local levels, countless health education conferences, seminars and meetings have taken place among departments of government, civic and community organizations, voluntary agencies, social service groups, educators and health care providers. The communications media continue to take an active part through public service spots, dramatic productions, special documentaries, publication of health columns, and special articles, among other activities. There is every reason to believe that these efforts will continue for the foreseeable future and be of great value in helping people make informed decisions as to their future state of health. This is being done without the additional mechanisms which are contemplated in HR 8278.

In this regard, I think it is appropriate to note the extent to which health education is a part of the overall effort of the American Medical Association. Our activities in combating medical quackery and in educating the public as to the hazards of quack preparations and appliances, and the dangers inherent in seeking health care from fringe practitioners, are well known. Our Department of Health Education works with a wide variety of schools, physicians, medical societies and others to help develop viable and responsive health education programs, pamphlets and informational resources. The Department publishes health education materials and answers a large number of requests for information each month. The AMA's monthly magazine, Today's Health, is entirely devoted to the health education of the public. In addition, programs of health education of the public are carried on as part of our activities in many areas, including the following: occupational safety and health; air, water and noise pollution; cosmetic and cutaneous health; foods and nutrition; drugs; automotive safety; exercise and physical fitness; alcoholism and drug abuse; mental health; radio, TV and motion pictures; public health; health care of the poor; rural health; and medical aspects of sports.

In addition to AMA's activities, ongoing programs of health education are being conducted by many medical specialty groups, the American Dental Association, state and county medical societies, 4-H clubs, National Safety Council, Boy Scouts of America, National Instructional TV, PTA, American Farm Bureau, American Hospital Association and virtually every voluntary health agency, among other groups.

Moreover, health education has long been a permanent part, in varying degrees, of the curricula of public and private schools. While these health education programs are of various content and value, their inclusion in the overall education program attests to the important part which health education is deemed to play in the educational process of children and young adults. It is this area that I believe holds the greatest promise for maximizing the positive aspects of health education programs.

Earlier this year, the Subcommittee on Elementary, Secondary and Vocational Education of the House Committee on Education and Labor held hearings on HR 2599, the Comprehensive School Health Education Act. The AMA appeared at those hearings and testified in strong support of that legislation which calls for comprehensive health education programs at the primary and secondary level as well as financial support for teacher training, demonstration projects and the development of comprehensive health education programs. We believe this is a productive and progressive means by which the Federal government can increase its present role in health education, and we would urge support of the programs contained in HR 2599 rather than those proposed in Title I of HR 8278. A well-founded comprehensive health education program can help children develop life-long good health habits and assist them in making intelligent and informed decisions concerning their future habits and lifestyle. We believe that this represents a good use of health education dollars.

We would like to comment specifically on the requirements set out in Section 1703(a)(1) of HR 8278 which state that the Secretary cannot approve an application of any health care facility for a grant or contract for institutional health services under the Public Health Service Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Treatment Act, or Title IV of the Drug Abuse Office and Treatment Act unless the applicant assures the Secretary that the applicant will provide health education to all persons receiving inpatient or outpatient services. This is an inappropriate and coercive requirement to place on applicants under these programs and places health education in an unfortunate light.

Health education should be an integral component of an individual's overall education and should include appropriate patient education at such time as it contributes to the individual's ability to assist in his health care and his early return to maximum activity. This will vary substantially among individuals and should be individually fashioned if it is to attain its greatest usefulness. This should not be a fixed standardized program mandated by law but rather an option to be considered on an individual basis.

Under the same general section (1703), there is a similar requirement placed on health care facilities participating in Title XIX—Medicaid. Many questions are raised by the provision. For example, is it the intent to make health education a specific benefit under these programs? If enacted, would this legislation provide for the reimbursement of providers for the costs of developing and carrying on a consumer health education program? Would it be required of all patients or just those under Medicaid? We do not believe that a requirement that all Medicaid providers of institutional health care carry on a program of health education is practical, feasible or appropriate. Health education programs, to be effective, must be responsive to the individual needs and resources of communities, patient populations and providers themselves.

There is ample authority already granted to the Secretary of HEW to carry on the studies and programs proposed by this legislation and no additional authority is needed nor would its effects strengthen present program initiatives. As has been previously pointed out, present authority and present activities in both the public and private sector, at all levels, make the enactment of this duplicative legislation a potential impediment to present ongoing programs and activities.

Title I of the legislation before you is, in our opinion, duplicative and unnecessary, and we recommend that it not be adopted. While the AMA is fully in support of health education and has committed a major portion of its resources and attention to it, we cannot be supportive of the creation of another large health bureaucracy. It is our view that the major thrust of health education efforts should be through the elementary and secondary school education system, with a second thrust of emphasis through patient education by the physician. We would urge the Committee's consideration and support of H.R. 2599 which will provide needed Federal support of health education programs for children and young adults as a part of their overall educational experience.

Title II of the legislation before you, the Disease Prevention and Control Amendments of 1975, would revise and extend for three years existing authorities for disease prevention and control programs contained in the Public Health Services Act and the Lead-Based Paint Poisoning Prevention Act. These programs, which provide financial support to public and non-profit private entities so as to enable them to carry on disease prevention and control activities, have consistently proven their worth in improving the public health on the local, state and national level. We believe these traditional programs are worthy of continued federal support and urge their extensions.

Also contained in Title II is an expansion of the programs for which Federal grants may be made to include diabetes, hypertension, cardiovascular diseases and RH abnormalities. While we would certainly not deny that these are serious and widespread conditions, they are not communicable diseases and should not be included in the authority for Federal support of communicable disease prevention and control programs. We would urge deletion of this change in present authorities.

We also note that the wording of Section 317(f) would seem to make the program so open-ended as to challenge definition. The Secretary is given authority to fund programs ". . . designed and conducted so as to contribute to national protection against diseases of national significance which are amenable to reduction." The language of this proposed authority would permit the Secretary to define these terms as he deems appropriate without appropriate guidance or control from the Congress. This broad authority is unnecessary and unwarranted, and we would recommend that the Secretary's responsibilities be limited to specifically named communicable diseases. The authorities of Section 317 of the Public Health Service Act which are pending before you are essential to the continuation of present programs and initiatives in the prevention, control and eradication of communicable diseases. We would urge the Congress' extension of these programs.

Also pending is the authority for a continuation of the program of Federal grants for research, demonstration projects and training programs for the prevention and control of venereal disease. The insidious resurgence of venereal disease has alarmed the entire health community. We would urge that the present authority be extended. In addition, we would recommend that this program be amended to specifically provide for Federal funding of state programs to finance the cost of gonorrhea screening in physicians' offices for those individuals who are unable to pay for these services. If this disease is to be controlled, it is essential that patient finances must not pose a barrier. This is a public health problem which must be controlled.

Thank you for this opportunity to comment on H.R. 8278 and we respectfully request that these comments be made a part of the Subcommittee's consideration of this legislation.

Sincerely,

JAMES H. SAMMONS, M.D.,
Executive Vice President.

AMERICAN NURSES' ASSOCIATION, INC.,
Kansas City, Mo., December 3, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Commerce and Health, U.S. House of Representatives, Washington, D.C.

DEAR MR. ROGERS: The American Nurses' Association supports the extension and revision proposed by Title II of H.R. 8278, the National Health Education and Disease Prevention Act of 1975.

This Association is pleased with the emphasis placed on disease prevention by this bill. We are concerned about the reported low levels of certain immunizations in some areas of our country. Community health and school health nurses, in particular, concentrate efforts on teaching families the importance of immunizations. Therefore, the Section in H.R. 8278 which provides for special consideration to applications for programs which will increase the immunization rate of any population not having received, or having failed to secure, immunizations, is especially important.

Also, any bill reported should contain provisions such as those in H.R. 8278, Section 317(b)(2)(b) which increase population awareness, and focus on access and prevention.

We commend you for your continued leadership and ask that this letter be made a part of the hearing record. We presented separate testimony on the health education title of the bill.

Sincerely,

EILEEN M. JACOBI, ED. D., R.N.,
Executive Director.

ST. LOUIS, MO., *January 6, 1976.*

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, House Interstate and Foreign Commerce Committee, Washington, D.C.

DEAR MR. ROGERS: It is very gratifying to know the Congress of the United States realizes in an economic sense the importance and need for programs of preventative medicine, and is citing nutrition as one of the components of the Health, Education and Disease Prevention Bill.

As a rule, registered dietitians are called upon to "right" nutritional situations that have been "wrong" for so many years that it is all but impossible for any change to take place. Or, in other circumstances, the medical problem is so severe that proper diet, at this late date, will only be able to control further complications.

With nutrition as part of the preventative medicine programs the number of severe medical problems suffered by a population that now has little education in the area of good nutrition and health in general will undoubtably be reduced. It has been proven that good nutritional care can prevent many diseases and serious medical problems. The difficulty has been in obtaining funds to provide this service where it is needed and in educating the population and medical profession of the importance of early detection and treatment of poor nutritional habits.

I think it is important that H.R. 8278 mention "registered dietitian" as the most appropriate person to deal with thhe nutritional assessment of various population centers [illegible] in dispensing of current nutritional information. When one thinks of medical care and information, it is generally accepted that a physician with an M.D. after the name will be providing that care and information. Anyone can call themselves a "nutritionist"; but a registered dietitian, R.D., is a true expert in nutritional matters and has specific recognized qualifications. Although there are exceptions to this, in that there are medical people who are experts in the field of nutrition; they usually depend on registered dietitians to interpret and instruct the public.

It seems to me there should be some clarification as to who comprises the National Institute for Health Information, Education and Promotion. Section 1711 (a). Is it up to the Director to appoint those members? The membership of the Institute will determine the direction it takes and will effect, for example, Section 1712 (a) (6) and (7). I can foresee instances where nutrition, as important as it is, easily overlooked by those whose primary interest is another aspect of care.

In Section 317(2)(B) appropriate nutritional measures need to be included. These should be determine by a registered dietitian.

In the section regarding the "National Council on Health Information, Education and Promotion", I would like to see a change in Section 1715(a)(2) to include a registered dietitian at all times. It is possible for physicians who ". . . have distinguished themselves in the fields of preventative medicine . . ." to not be aware of the contribution a registered dietitian can make. It has taken the American Dietetic Association too long to proclaim the expertise and professionalism of its members. Todays registered dietitian is truly the most qualified person in regard to nutrition and its use in preventative medicine.

In conclusion, because the role of the registered dietitian is not as well known as it should be, I think this position should be clearly stated in H.R. 8278, so that the excellent intention of providing optimal medical and nutritional care is not lost. If I have overlooked any other section where a clarification for nutritional care is appropriate, due to my inexperience with legislation, please adjust them.

Thank you for considering this testimony in regard to H.R. 8278, the Health, Education and Disease Prevention Bill.

Sincerely yours,

STEPHANIE TRANEN, R.D.

MRS. DONNA LA ROCK,
St. Charles, Mo., January 6, 1976.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, House Interstate and Foreign Commerce Committee, Washington, D.C.

DEAR SIR: I am a registered dietitian and a member of the American Dietetic Association. My current position is with the Nutrition Clinic, Washington University Clinics at Barnes Hospital in St. Louis. Senator Stewart Symington suggested that I write to you.

In the Nutrition Clinic we see both private and clinic patients for initial nutrition consultation and also for follow-up. The majority of our patients are seen for dietary treatment of obesity, diabetes, and/or hypertension. We have seen a tremendous increase in the demand for nutrition care, in referrals from both private and clinic physicians. Our census has doubled in the past three years. In 1975 over 5,000 patient visits were made.

In the initial visit to our clinic, a patient's nutrition history is assessed. The reasoning behind his dietary restriction is discussed; how it will help his well-being. The diet is then planned with the aid of the patient and questions are discussed and the diet plan is altered if necessary. We have found both diet plan individualization and close follow-up extremely important in maintaining patient motivation and increasing success.

Nutrition consultation reimbursement would be of extreme benefit to our patients. I believe we would see a greater dietary success rate because patients would be more able to return for follow-up if there were some monetary assistance. Also, we would be able to reach a greater number of people if the cost of our nutrition council were not a deterrent.

Nutrition care is essential in all health care programs. As a preventative and therapeutic tool it can help decrease or prevent costly hospitalization and visits to the physician. It can improve public health and save health care dollars.

I feel it is essential that nutrition care be included in the Health, Education, and Disease Prevention Bill HR8278.

Sincerely,

DONNA LA ROCK.

[Whereupon, at 12:15 p.m., the hearing adjourned.]

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